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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZUEM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00419

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245153

August 19, 2015

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

Dear Ms. Redalen:

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

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

Effective July 31, 2015 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 19, 2015

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

RE: Project Number S5153024

Dear Ms. Redalen:

On July 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 1, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 23, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 1, 2015, effective July 31, 2015 and therefore remedies outlined in our letter to you dated July 10, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing	8/15/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/31/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **07/17/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **07/31/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/17/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **07/31/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	08/19/2015	10160	08/15/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/1/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245153	A. Building B. Wing 01 - MAIN BUILDING 01	7/23/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	07/17/2015	ID Prefix Reg. # NFPA 101 LSC K0067	07/17/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/kfd	08/19/2015	25822	07/23/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 6/29/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245153	02 - 2008 ADDITION	7/23/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 07/17/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 08/19/2015	**Signature of Surveyor:** 25822	**Date:** 07/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/29/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZUEM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00419

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH
Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 10, 2015

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

RE: Project Number S5153024

Dear Ms. Redalen:

On July 1, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 10, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 1, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 1 of 2 residents (R113) reviewed for admission, transfer, and discharge was provided with adequate notice of a room change. Findings include: R113's quarterly Minimum Data Set (MDS) dated 6/12/15, identified R113 had intact cognition. During interview on 6/29/15, at 6:59 p.m. R113 stated she had been in a different room when she was first admitted to the facility, but was told one	F 247	The staff at Madonna Towers of Rochester, Inc. respect the residents¿ right to receive notice before the resident¿s room or roommate is changed. The staff is sensitive to the trauma that a room change causes some residents and attempt to be as accommodating as possible. The resident is asked about his/her preferences which are than taken into account when discussing changes of rooms and the timing of such changes. When a resident is moved at the facility¿s request, an explanation of the reason for	7/31/15

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

Electronically Signed | 07/20/2015

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F 247	Continued From page 1 day she had to move to a room on a different hall, adding "That kind of upset me." Further, R113 stated she would have liked to have had more notice so she could prepare herself to make the move. R113 stated, "I would have liked notice." R113's progress note dated 6/11/15, identified R113 "...moved from [old room number] to [new room number] today. Social services will check in with resident next week on room adjustment." However, the progress note lacked any reason for the room change, nor any evidence R113 had been given notice prior to being moved. During interview on 6/30/15, at 1:35 p.m. trained medication aide (TMA)-A stated R113 had changed rooms recently. Further, TMA-A stated the residents should be given notice before being moved. TMA-A stated, "Because we [staff] know about it", adding staff are aware of room changes "a couple days" before they occur. On 6/30/15, at 2:21 p.m. registered nurse (RN)-A and licensed social worker (LSW)-A were interviewed regarding R113's lack of notice before having a room change. RN-A stated staff speak with residents and their family to determine if a room change is needed to determine "whatever is the best fit." R113 had not been making the desired progress with therapies, and was going to stay "longer term than expected" so she needed to change rooms off of the short term wing. RN-A spoke to R113 about the move "probably the day of, or the day after she moved." Further RN-A added she was unaware how much notice residents were typically given before having a room change, "I don't think there is a process." LSW-A stated she told R113 about changing rooms on 6/10/15. R113 had questioned when	F 247	the move is provided. The resident is given the opportunity to see the new location and ask questions about the move. The policy for room change notification and documentation will be reviewed and revised. During the mandatory meetings July 21, 2015, the staff will be instructed on the room change notification procedures and requirements. The events surrounding the room change for resident number 4 were reviewed as part of the facility¿s continuing quality improvement process. Resident number 4 ¿ The resident was moved to the long-term care unit on June 11, 2015 after meeting the therapy restorative goals on the short-term rehabilitation unit. The possibility of a room change had been discussed with the resident on numerous occasions prior to the actual move. Although the resident¿s preference was to remain on the short-term rehabilitation unit, she was accepting and understood the rationale of the move to the long-term unit. During the June 11, 2015 visit with the social worker, the resident was noted to be organizing her belongings and stated she was comfortable in the new room. During the June 16, 2015 visit, the resident told the social worker she was ¿doing okay¿ in her new room. During the July 10, 2015 visit with the social worker, the resident reported that she had started on a new medication and was looking forward to an improvement in her mobility. She thanked	

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F 247	Continued From page 2 she would be moving, and was told "they [staff] are looking at tomorrow." R113 was unhappy with the lack of notice, "but accepted it." R113 had an appointment the following day, on 6/11/15, and requested to wait until after she had returned to move her belongings. However, when she was away at the appointment, staff had moved her belongings despite her wishes not too until her return from her appointment. LSW-A stated R113 was upset when she returned and found her belongings moved. Further, LSW-A stated R113's room change "probably could of" been handled differently, and added "we can always improve." A facility Room Change policy dated 01/2015, identified, "Residents have the right to be informed when there is a change in room. Residents will receive a 7 day advanced written notice regarding the room change." Further, the policy identified a procedure which included, "Social Services will provide coordination of the move by preparing the resident and responsible party for the move emotionally as well as assisting with the move of personal belongings."	F 247	the social worker for ¿being my friend.¿ During the July 16, 2015 social worker visit, the resident reported that she is comfortable in her room and declined an offer to move to another available room. The social worker frequently chats with the resident during the day; the resident is interactive and engaging. The social worker will continue to monitor the resident¿s satisfaction with her current room on a routine basis. The Director of Nursing/Designee will audit records of resident changing rooms weekly for four weeks to verify that resident received adequate notice prior to room changes initiated by the facility. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		7/31/15

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F 279	Continued From page 3 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plan interventions for bilateral leg skin problems for 1 of 2 residents (R74) reviewed for non-pressure related skin injuries. Findings include: R74 was admitted to the facility on 8/7/14, with diagnosis that included hip fracture, dysphagia, and dementia according to R74's undated care plan. During observations on 6/29/15, at 2:00 p.m., R74 was seated in a wheelchair in resident's room, dressed neatly. Observations at that time revealed R74 right leg calf covered in red areas from below the knee to the ankle and left leg from below the knee to ankle was covered in faded red areas. R74 stated did not know what the areas were on the legs. The facility identified R74 on the quarterly Minimum Data Set (MDS), an assessment dated 4/24/15, to have intact cognition, required	F 279	Madonna Towers of Rochester uses the results of the comprehensive assessment to develop, review and revise the resident¿s comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident¿s needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident¿s highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents¿ right to refuse cares/services. The care plan and skin risk policies/procedures were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment. During the mandatory meetings July 21,	

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F 279	Continued From page 4 extensive assist of one staff for activities of daily living, and had no other skin problems. Document review of R74's quarterly skin assessment dated 4/29/15, identified no pressure ulcers, no venous and arterial ulcers, and had open lesions other than ulcers, rashes, cuts, left temple skin cancer removed. Interventions included skin monitored two times a day with cares. Document review of R74's care plan problem, dated 8/31/14, directed staff R74 had alteration in skin integrity related to history of pressure ulcers, impaired mobility, risk identified on skin risk observation tool, advanced age, and history of skin impairment on right buttock. Interventions included pressure reduction mattress bed and cushion to chair, keep clean and dry, monitor skin with cares, follow up with wound nurse as needed, incontinent care, and reposition as indicated. The care plan did not address red areas on legs. During interview on 6/30/15, at 3:40 p.m., assistant director of nursing (ADON)/registered nurse (RN)-Q and RN-D verified neither had been aware of the reddened areas on R74's legs. RN-D verified the lack of documentation identifying reddened areas on legs. During interview on 6/30/15, at 3:45 p.m., nursing assistant (NA)-C stated R74 had the reddened areas on both legs for at least one month. NA-C stated had notified a nurse who then applied lotion to the legs. During interview on 6/30/15, at 4:00 p.m., RN-B stated was aware of the reddened areas on both	F 279	2015, the nursing staff were instructed 1) on the facility policies for care plan content/reviews/updates 2) that the residents¿ care plans must be current at all times and 3) that care plans address skin problems/treatments. The certified nursing assistants were instructed that the bath sheets should indicate the location of skin redness/rashes as well as other skin abnormalities/changes. The care plan for resident number 74 was reviewed and revised to reflect the recurring rash to her bilateral lower legs. The certified nursing assistant care guide has been updated and instructs the direct care staff to observe for the rash and report to the licensed nurse if it is present. The physician¿s order was reviewed and appropriately addresses where and when to apply the cream to treat the rash. The staff has requested that the physician/nurse practitioner observe and address the ongoing rash during the next routine visit. Compliance will be monitored by the MDS Coordinator; the care plans of residents who have skin problems identified during the completion of the minimum data set will be audited for two months to ensure the skin problem are appropriately addressed. The care plans will also be audited to ensure that wounds listed on the wound tracking sheet utilized by the Assistant Director of Nurses and the skin issues discussed during Monday through Friday interdisciplinary meetings are appropriately addressed. Compliance will	

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F 279	Continued From page 5 legs and had applied triamcinolone cream to the areas, most recently on 6/27/15. RN-B stated not aware if the reddened areas had been evaluated by a physician. Document review of nursing assistant bath sheets revealed instructions to "Circle any parts of the body below where you see: Bruises, redness/discolorations or darkening of skin, rash, open areas, skin tears or wounds." Review of bath sheets dated 6/26/15, hand written entry stated, "rash, Vanicream on ongoing rash." There was no indication of where the rash was located. Document review of physician orders with start date of 8/7/14, revealed orders for triamcinolone cream 0.1% apply thin layer two times a day as needed. The orders did not identify where to apply triamcinolone cream. Document review of physician orders dated 6/15/15, revealed orders for triamcinolone cream 0.1% apply thin layer two times a day as needed to rash on legs. Document review of facility medication administration record dated 4/1/15 to 4/30/15, and 5/1/15 to 5/31/15, revealed triamcinolone cream two times a day as needed, with a start date of 8/7/14, no indication of where the affected area was located, and none was documented as administered. A hand written note on the May medication administration record dated 5/11/15, revealed the cream was discontinued. Document review of facility medication administration record dated 6/1/15 to 6/30/15, revealed triamcinolone cream two times a day as needed to rash on legs with a start date of 6/15/15. Document review revealed the cream had been applied on 6/15/15, 6/27/15, and 6/30/15.	F 279	be reviewed at the quarterly Quality Council meeting.	

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F 279	Continued From page 6 During interview on 7/1/15, at 10:45 a.m., RN-Q verified R74 was admitted to the facility with ongoing bilateral leg rash. RN-Q verified R74's care plan lacked identification of ongoing bilateral reddened legs and staff instructions for care of the red areas. During interview at that time, RN-D stated had just talked with family member who stated R74 had rash on legs "on and off " for years. Review of facility policy: Care Planning Process dated 8/2014: read on page 2, #4, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." "... Have treatment objectives with measurable outcomes."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		7/31/15

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F 280	Continued From page 7 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure timely revision of the comprehensive plan of care to include a developed pressure ulcer for 1 of 1 resident (R4) reviewed for pressure ulcers. Findings include: R4's annual Minimum Data Set (MDS) dated 4/10/15, identified R4 had severe cognitive impairment, was at risk for developing pressure ulcers, but had no current pressure ulcers. During interview on 6/30/15, at 8:20 a.m. registered nurse (RN)-E stated R4 likes to wear her shoes, and obtained an unstageable pressure ulcer (full thickness tissue loss but the wound base is covered by slough or scabbing) as a result of the shoes. R4's Resident Progress Note dated 5/23/15, identified, "Resident c/o [complained of] pain in right foot this morning. Inspection revealed a small open area [pressure ulcer] surrounded by red, inflamed skin." A subsequent progress note dated 5/24/15, identified, "The sore [pressure ulcer] appears to have been caused by her shoe. A pair of gripper socks [soft socks used to reduce pressure] was applied and the resident was instructed to not wear shoes."	F 280	Madonna Towers of Rochester, Inc. staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents¿ functional abilities and quality of life. The residents and their families/legal representative are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. During mandatory meetings July 21, 2015, the nursing staff were 1) informed of the regulatory requirement that the residents¿ care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates and 3) reminded of the importance of addressing skin problems/risks in the plan of care. A registered nurse weekly assesses and	

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F 280	Continued From page 8 During interview on 6/30/15, at 1:19 p.m. nursing assistant (NA)-A stated she was unaware of R4's pressure ulcer on her right foot or of any interventions that were being done for it. Further, NA-A stated staff check the resident care guide for updates, adding the care guide is created from the residents comprehensive care plan. R4's care guide, dated 6/29/15, identified R4 was a "LOW RISK" of skin breakdown. The care guide lacked any indication R4 had a current pressure ulcer on her right foot, nor any interventions for staff to follow to promote healing and reduce the risk of infection to the pressure ulcer. R4's care plan dated 4/30/15, identified R4 had "potential for alteration in skin integrity r/t [related to]; decreased mobility and new shoes 4/2015." The care plan lacked any indication of R4's pressure ulcer on her right foot nor any interventions for staff to follow to promote healing or reduce the risk of infection in the pressure ulcer. During interview on 6/30/15, at 2:06 p.m. NA-B stated R4 had no pressure ulcers "that I know of." NA-B stated she would use R4's care guide to locate interventions if she had a pressure ulcer, "We're always told to go by our care guide." NA-B stated it was "very important" the care guides are correct and up to date for R4. Further, NA-B stated R4 was not currently wearing her shoes because of swelling in her feet, not because of any skin concerns. When interviewed on 6/30/15, at 3:15 p.m. RN-B stated R4's care plan should have been updated to include her developed pressure ulcer and	F 280	documents observations for pressure related skin lesions. Skin monitoring by the direct care staff and charge nurses is part of the weekly bathing process. Resident number 4 ¿ A registered nurse reassessed the pressure ulcer on the top of the resident¿s right foot noting, ¿wound continues to heal slowly. Today¿s measurements were .3 cm x .3 cm x .0 cm (scabbed over).¿ This is a decrease in size from the previous assessment. The care plan and nursing assistant care guides have been updated to reflect that the resident is not to wear shoes until the ulcer is healed. A registered nurse will continue to monitor the scabbed area on a weekly basis until resolved. The care plan has been reviewed and revised to address the pressure area on the right foot. To monitor compliance the Assistant Director of Nursing/Designee will conduct random audits of the skin related care plans weekly for four weeks. If care plan omissions or inaccuracies are identified, additional care plan audits and staff training will be done. The interdisciplinary team will continue to review care plans for completeness, accuracy, and relevancy during the residents¿ quarterly care conferences, with a significant changes in condition, and more often if necessary. Compliance will be reviewed at the quarterly Quality Council meeting.	

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F 280	Continued From page 9 identified the intervention of leaving R4's shoes off to reduce the pressure on the skin of her feet. Further, RN-B stated the care plan is used "so we know how to care for our residents." At 3:40 p.m. RN-B approached the surveyor and stated she located R4's current comprehensive care plan, but added, "we don't see this." RN-B stated she had never been shown to access a residents care plan, but were told by the former director of nursing (DON) to "just play around with the computer" and learn how to find it. Further, RN-B stated she would have liked education on how to change a residents care plan. During interview on 6/30/15, at 3:50 p.m. RN-C stated R4 developed a small pressure ulcer on the top of her right foot from wearing tight fitting shoes. The pressure ulcer was "unstageable" currently, and the intervention to reduce it and promote healing was to remove her shoes and wear gripper socks. Further, RN-C stated R4's care plan and care guide should have been updated to include the pressure ulcer and the current interventions for it. A facility Care Planning Process policy, dated 8/14, identified a care plan should be "periodically reviewed and revised by a team of qualified persons after each assessment." The resident care plan should describe, "Services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." Further, the policy identified the care plan should be "updated following any changes in status or as a resident condition/orders change..."	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		7/31/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify target behaviors and monitoring effectiveness of the medication for 1 of 5 residents (R95) reviewed for unnecessary medication use and who was prescribed antipsychotic medication. Findings include: R95 was observed on 6/29/15, at 2:15 p.m. R95 was resting in bed awake, and stated, "Can you get in here and get to the door I have my boots	F 329	Madonna Towers of Rochester staff ensure that each resident¿s drug regime is free from unnecessary drugs. The resident¿s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse	

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F 329	Continued From page 11 on." R95 had socks on. R95 then reached out in front of her, opened and closed her hands repeatedly as if she was reaching or grabbing at something that was not there. As R95 reached/grabbed she stated, "Are you here, I'm not hiding, however we can transfer our stuff." R95 then put her head down, put her hands to her forehead and shook head gently back and forth and patted her forehead and the sides of her head as if she had a headache or was deep in thought. R95 then dropped her hands to her lap and continued to fidget. R95 was admitted to the facility on 4/14/2015 according to the facility admission record and had diagnoses that included but not limited to senile dementia with delusions and behavioral disturbance. R95's admission Minimum Data Set (MDS) dated 4/20/15 indicated severe cognitive impairment had not had behaviors during the assessment period, and an antipsychotic medication had been used. In addition the MDS revealed a PHQ-9 (mood assessment to determine signs and symptoms of depression) score of zero indicating no depressive signs or symptoms. R95's physician orders provided by the facility on 7/01/2015 included the order for Zyprexa (antipsychotic medication) 2.5 milligrams (mg) in the morning and 5 mg in the evening before bed for senile dementia with delusions. R95's electronic care plan provided by the facility on 7/1/2015. The care plan identified psychotropic drug use related to dementia with agitation and history of delusions however, did not identify individualized target behaviors and failed to define R95's delusions. The care plan included generalized interventions of "reapproach, different staff, offer food/fluids." In the absence of individualized target behaviors, it	F 329	consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated. Based on the resident¿s comprehensive assessment, Madonna Towers of Rochester staff routinely identify target behaviors that justify the use of psychotropic medications. The policy and procedures for administration of psychotropic medications were reviewed and revised. For residents receiving antipsychotic medications, the medication administration record has been modified to include designated space to record the resident¿s target behavior(s), the number of times the behavior was observed, the attempted intervention(s) to modify the behavior, and the effectiveness of the intervention(s). The target behavior(s) will be specified in the plan of care. All residents will be reviewed to determine the need for identification and monitoring of target behaviors and related interventions. Care plans and medication administration records will be revised as needed. The interdisciplinary care team	

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F 329	Continued From page 12 could not be determined when nonpharmacological interventions nor if Zyprexa was affective in relieving delusions. April 2015 pharmacy medication regimen review communication form to the facility indicated the consulting pharmacist identified the absence of individualized target behaviors and monitoring. The pharmacist medication regimen review read, "...please be certain target behaviors have been clearly and specifically identified and are being monitored objectively and qualitatively..." The Medication Regimen Review chart form dated 5/25/15 and June, 2015 again identified by the by the consulting pharmacist the absence of target behavior identification and monitoring. During an interview on 7/1/2015, at 10:52 a.m. licensed social worker (LSW)-A explained the LSW was responsible for creating the behavioral care plan and verified individualized target behaviors were not identified on care plan. LSW-A verified a comprehensive evaluation for medication effectiveness had not been completed since R95's admission. LSW-A stated the tracking on the computer completed by nursing assistants for behaviors and interventions were "generic" in nature. Facility policy Antipsychotic Medication Use last revised 3/14 lacked specific direction on how to identify resident specific target behaviors and interventions and lacked direction on monitoring and timeliness of evaluation(s) for determining if nonpharmacological interventions and medication had been effective to justify the continued use of the antipsychotic medication.	F 329	will review significant changes in behaviors, new psychotropic medication orders, psychotropic medication dose reductions, and target behaviors/interventions on a monthly basis and more frequently if needed. During the mandatory meetings on July 21, 2015, the licensed nursing staff will be instructed on the new documentation procedure for target behaviors. All direct care staff will be reminded of the importance of being observant and reporting target behaviors to the charge nurse. During the consultant pharmacist¿s monthly medication audits and the quarterly care planning process, the resident¿s medications will continue to be reviewed to assure that the resident is receiving the lowest effective medication dose with appropriate indications and monitoring. The care plan of resident number 95 was reviewed; individualized target behaviors and related interventions were added. Behavior symptoms, psychotropic medication use, and the effectiveness of interventions will continue to be monitored. The care plan will be updated to reflect changes. The resident is currently receiving hospice services. Compliance will be monitored by the Director of Nursing/designee through an audit of the care plans and medication administration records to ensure that target behaviors are identified and quantified. The behavior tracking	

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F 329	Continued From page 13	F 329	documented on the medication administration records of residents receiving antipsychotic medications will be audited monthly for three months. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 9 residents (R59, R29) received medication in accordance with physician orders and pharmacy instruction. This resulted in a facility medication error rate of 6.89% (percent). Findings include: R59's quarterly Minimum Data Set (MDS) dated 4/10/15, identified R59 had no cognitive impairment. R59's signed Physician Order Report dated 5/12/15, identified an order of, "aspirin tablet, chewable; 81 mg [milligrams]; oral ... once a day..." During observation of medication administration on 6/30/15, at 8:35 a.m. licensed practical nurse (LPN)-A prepared R59's medications at a mobile cart outside the dining room. LPN-A removed a	F 332	The facility¿s goal is to have a medication error rate of less than 5% and be free of all significant medication errors. Madonna Towers of Rochester has policies and procedures requiring that the preparation and administration of drugs and biologicals are in accordance with 1) physicians¿ orders 2) manufacturers¿ specifications and 3) accepted professional standards and principles. The medication administration policies and procedures were reviewed and found appropriate. The nurses and trained medication aides (TMAs) were instructed to review the facility¿s Medication Administration policy and procedures as well as the reference information on the 5 rights of medication administration (right resident, medication, dose, route and	7/17/15

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F 332	Continued From page 14 white bottle of aspirin 81 mg and poured two pills inside a clear cup in addition with R59's other prescribed medications. LPN-A turned to leave the cart and administer the prepared medications to R59 who was seated in the dining room, and was stopped by the surveyor. LPN-A and the surveyor removed the medications from the clear cup and reviewed them identifying LPN-A had placed two aspirin in the cup when R59's signed physician orders called for one. LPN-A stated R59 should only have one aspirin and added, "I must have done it twice." R29's quarterly MDS dated, 5/14/15, identified R29 had moderate cognitive impairment. R29's signed Physician Order Report dated 5/28/15, identified an order of, "Flonase (fluticasone) [a nasal spray used to reduce inflammation] spray, suspension; 50 mcg [micrograms]/actuation; nasal ... 1 spray each nostril BID [twice a day]..." During observation of medication administration on 6/30/15, at 3:33 p.m. trained medication aide (TMA)-A removed R29's Flonase medication from a mobile cart by the nurses station and provided it to the surveyor for review. The label identified the correct medication, but further had a blue sticker affixed to it which read, "SHAKE WELL." However, TMA-A did not shake the vial of Flonase as instructed, and provided the medication to R29 who was seated in his room. When interviewed after the administration of medication to R29 on 6/30/15, at 3:37 p.m. TMA-A stated she did not shake the Flonase as instructed, but should have "so it mixes the medicine." During interview on 7/1/15, at 10:47 a.m. LPN-B	F 332	time). The nurses and TMAs were also reminded of the need to check for specific instructions for drug administration. The nurses and trained medication aides signed to verify receipt/review of the educational material. The related state and federal regulations and the facility¿s policies and procedures for medication administration will also be reenforced with the licensed nurses and TMAs during the July 21, 2015 mandatory meeting. The Director of Nurses/designee and Consultant Pharmacist will monitor for compliance by conducting weekly random observations of medication passes for four weeks. Observations will include medication administration for residents number 29 and 59. If an unacceptable medication error rate is noted, additional auditing and staff training will be done. Medication errors will continue to be tracked and evaluated for frequency and need for corrective action. Compliance will be reviewed at the quarterly Quality Council meetings.	

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F 332	Continued From page 15 stated TMA-A should have shaken R29's vial of Flonase prior to administering it "to mix up the medication", as if not done the suspension of medicine "kind of separates." The medication is shaken well prior to administration "to make sure you get the correct dosage." Further, LPN-B stated nurses are taught to triple check orders prior to giving medication, and if R59 had been given two aspirin instead of the ordered one, it would lead to potential increased bleeding. When interviewed on 7/1/15, at 11:11 a.m. the director of nursing (DON) stated R59 should have only had one aspirin prepared for administration, and TMA-A should have followed the pharmacy instructions for R29's Flonase and shaken it prior to administering it. Further, the DON added, "I expect them [staff] to follow the Rights [" five rights " : the right patient, the right drug, the right dose, the right route, and the right time], of medication administration." When interviewed on 7/1/15, at 2:02 p.m. the consulting pharmacist (CP) stated R29's Flonase was a suspension and "should be shaken" prior to being given. Further, R59 should have only been prepared one aspirin according to her current physician orders, "that would be an error" had two doses been given. A facility Medication Administration by Licensed and Non-Licensed Personnel policy, dated 10/14, identified, "Medications are administered in accordance with the written orders of the attending physician or nurse practitioner." Further, the policy directed staff to, "Read and follow any special instructions written on labels."	F 332		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		7/31/15

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F 425 SS=C	Continued From page 16 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure stock filled medications (stored medications that can used for anybody in the facility) were available for resident use, and not expired. This had potential for affect all 58 residents residing in the facility at the time of the survey. Findings include: During observation of medication storage in the West Medication Room with licensed practical nurse (LPN)-B on 6/29/15, at 11:55 a.m. the	F 425	Madonna Towers of Rochester provides pharmaceutical services (including procedures that ensures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of pharmaceutical services and procedures. The facility utilizes only persons authorized under state requirements to	

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F 425	Continued From page 17 following expired medications were found in the cabinet of stock medications: 12 Sunmark "Ready To Use" enemas (a saline laxative used to relieve constipation). LPN-B stated the enemas were available for resident use as everyone in the facility has a current standing order for them. LPN-B was unaware of a facility process for ensuring the enemas and other stock medications in the supply were monitored for expiration adding, "no one is specifically assigned." Further, LPN-B stated the medications should have been removed when they expired and should "absolutely not" be available for resident use in the medication room. During interview on 6/29/15, at 12:40 p.m. the dispensing pharmacist (DP) stated expired enemas are "not guaranteed its full potency", and should have been removed from the supply when they expired. The pharmacy was not responsible for reviewing the facility stock medications for expiration, nor was DP aware of any process the facility had in place to do so. Further, DP stated it was the facility staff' responsibility to check for expiration dates on their stock medications. When interviewed on 6/29/15, at 3:30 p.m. the director of nursing (DON) stated the facility relied on "on-going" monitoring for stock medication expiration dates, however she was not aware if anyone was specifically assigned to do so. Further, the DON stated the expired medications should have been removed from the medication room. A facility Medication Storage policy, dated	F 425	administer medications. The Medication Storage policy and procedures were reviewed and revised to include audits of stock supply storage areas for expired medications/biologicals. All nurses and trained medication aides (TMAs) were required to review the Medication Storage policy and related procedures and sign to verify understanding. According to policy, the night nurse will check refrigerators, medication carts and medication/treatment supply storage areas for expired medications and supplies. Outdated items will be discarded per facility policy. Medication storage regulations and related facility policies/procedures will again be addressed during the July 21, 2015-mandatory meeting. All refrigerators, medication carts, and other pharmaceutical/biological/treatment supply storage areas have been checked for expired items. The outdated enemas were disposed of immediately. To monitor compliance, the Director of Nursing/Designee will check the medication storage areas for expired medication monthly for three months. If outdated pharmaceuticals/biologicals/supplies are found, additional monitoring and staff training will be done. The consultant pharmacist will randomly check for outdated/expired medications on a monthly basis. Compliance will be	

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F 425	Continued From page 18 07/2013, identified, "Drugs shall not be kept on hand after the expiration date on the label and no contaminated or deteriorated drugs shall be available. On a weekly basis the night nurse will check both the refrigerator and medication carts for expired medications, remove them and dispose per disposal policy." Further, "Medications procurable without prescription may be retained in stock supply in the medication room of Med carts. These shall have a manufacture date on the label and a date when opened to prevent the accumulation of outdated or deteriorated items."	F 425	reviewed at the quarterly Quality Council meeting.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to take action in regards to the consultant pharmacy recommendations for target behaviors for 1 of 5 residents (R95) reviewed for unnecessary medications. Findings include: R95 was admitted to the facility on 4/14/2015	F 428	The goal of Madonna Towers of Rochester is to prevent or minimize adverse consequences related to medication therapy. Many residents require multiple medications leading to complex medication regimens which increase the risk of adverse consequences. Transitions in care such	7/17/15

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F 428	Continued From page 19 according to the facility admission record and had diagnoses that included but not limited to senile dementia with delusions and behavioral disturbance. R95's physician orders provided by the facility on 7/01/2015 included the order for Zyprexa (antipsychotic medication) 2.5 milligrams (mg) in the morning and 5 mg in the evening before bed for senile dementia with delusions. April 2015 pharmacy medication regimen review communication form to the facility indicated the consulting pharmacist identified the absence of individualized target behaviors and monitoring. The pharmacist medication regimen review read, "...please be certain target behaviors have been clearly and specifically identified and are being monitored objectively and qualitatively..." The Medication Regimen Review chart form for May and June 2015 also identified the absence of target behavior identification and monitoring by the consulting pharmacist. Facility policy Antipsychotic Medication Use last revised 3/14 lacked specific direction on how to identify specific target behaviors and interventions and lacked direction on monitoring and timeliness of evaluation(s) for effectiveness and justification.	F 428	as a move from home or hospital to the nursing home, or vice versa, increase the risk of medication-related issues. To reduce the risk of adverse drug effects, the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist. The pharmacist routinely reports irregularities to the attending physician, and the director of nursing, and these reports are routinely acted upon. The policies and procedures for communicating and acting on the consultant pharmacist¿s recommendations were reviewed and revised. The nurse clinical managers were instructed to review the facilities Pharmacist Recommendations, Documentation and Communication Of. The clinical managers signed to verify receipt/review of the educational material. The related state and federal regulations and the facilities policy and procedure for Pharmacist Recommendations, Documentation and Communication Of will also be reinforced with the licensed nurses during the July 21, 2015 mandatory meeting. The licensed nurses will be informed of the need to review and respond in a timely manner to the pharmacist¿s recommendation to the nursing staff such as identifying and monitoring target behaviors. The care plan of resident number 95 was reviewed; individualized target behaviors and related interventions were added. Behavior symptoms, psychotropic medication use, and the effectiveness of	

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F 428	Continued From page 20	F 428	interventions will continue to be monitored. The care plan was updated to reflect changes. The resident is currently receiving hospice services. Compliance will be monitored by the Director of Nursing/designee by auditing records for three month and randomly thereafter to ensure appropriate follow up to the pharmacist¿s nursing recommendations. If noncompliance is noted, additional auditing and staff training will be done. During the routine monthly visits, the consulting pharmacist will continue to monitor for appropriate follow up to the nurse¿s and physician¿s recommendations. Compliance will be reviewed at the quarterly Quality Council meeting.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an environment was maintained clean and in good state of repair for 3 of 5 resident rooms reviewed. Findings include: An environmental tour was conducted with the	F 465	It is the policy of Madonna Towers of Rochester to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. As part of an ongoing process to provide a pleasant, homelike environment, Madonna Towers of Rochester has a	7/31/15

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F 465	Continued From page 21 maintenance manager (MM)-A and MM-B on 6-30-15 at 2:19 p.m. with the following findings: Room C-120's wheelchair seat cushion is a light yellow foam, which did not have a cover around it. In the same room, the door to the hallway, frame/jam protector, is loose and falls off when touched. The bathroom wall has a scrape where the paint is scrapped off. The scrape was located a foot above the floor. Both MM-A and MM-B agreed these issues were a problem. In room C-123 the resident's wheelchair's left leg rest had torn and jagged vinyl with the padding exposed. Pieces of vinyl were also missing. MM-A and MM-B both agreed the vinyl is worn out and needs replacing. It was not a cleanable surface and was a safety risk. In room C-122, the wheel chair was dirty with a thick coat of dust type of material on the metal poles under the chair seat and also had food debris attached to the chair frame. MM-A and MM-B verified the dirty chair. An interview on 07/01/2015 at 7:13 a.m. with housekeeping staff (HS)-A stated the wheelchairs are suppose to be washed once a week. She said she attempts to wash the wheelchairs but there is no cleaning schedule. An interview on 07/01/2015 at 7:35 a.m. HS-B stated if i see a dirty chair I clean it. "I don't have a cleaning schedule right now, so I could miss a wheelchair." During an interview on 07-01-15 at 8:05 a.m. MM-A confirmed he is not aware of a cleaning schedule for the wheelchairs. He also stated	F 465	schedule for routine cleaning, repairs, and maintenance of the facility and equipment. All staff members are expected to report environmental concerns through the Madonna Towers work order process. A maintenance check list will continue to be used for inspection of resident rooms at the time of discharge and at least yearly. The condition of the walls, ceilings, radiators, and doors will be checked; damaged equipment and furnishings will be repaired/replaced as needed. The wheelchair washing policy has been reviewed. Wheelchairs are scheduled to be cleaned monthly and more often if needed. A wheelchair washing log is maintained to ensure that all wheelchairs are cleaned on a rotating basis. The wheelchairs will be inspected when cleaned and any needed repairs will be reported to the maintenance department. During the mandatory staff meetings July 21, 2015, all staff will be reminded to be observant for equipment/furnishings/structures that need to be repaired or replaced. The procedures for reporting work items to the environmental services staff will be reviewed. Room C-120 B The uncovered foam cushion observed in the wheelchair has been removed from service. The scrape in the bathroom wall has been repaired and repainted. The loose frame/jam protector has been secured.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	07/01/2015

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F 465	Continued From page 22 there is not a maintenance or safety inspection process for the facility.	F 465	Room C-123 B The vinyl padding on the wheelchair left leg rest has been repaired. Room C-122 B The wheelchair observed in the room has been cleaned. Compliance will be monitored by the Director of Maintenance through direct observation and review of the cleaning/repair orders, checklists, and logs. If noncompliance is noted additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Council meeting.	
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water policy did not include an estimate of how much is needed to meet the residents, visitors, and staff needs during an interruption to city water. This had the potential to affect all 58 current residents of the facility, as well as staff and visitors. Findings include: The facility's emergency water procedure, entitled	F 466	Madonna Towers of Rochester has policies and protocols to ensure that water is available to essential areas when there is a loss of normal water supply. The policy defines the source of water, provisions for storing the water, both potable and non-potable, a method for distributing water, and a method for estimating the volume of water required. The water policy was reviewed and revised to include the amount of water	7/31/15

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F 466	Continued From page 23 loss of potable water and revised 4/2015, included information about the sources of the facility's water supply from the city. The document did not include any specific information about procurement of an alternative water supply, nor did it present any procedure for calculating the estimated amount of emergency water required, to meet the needs of the residents and staff in the facility at the time of the need. Further, the document lacked any direction or arrangement for distribution of water in the facility to residents, dietary, staff and other departments who utilize water, should there be a loss of city water supply. During an interview on 7/1/15 at 12:27 p.m. the facility manager (FM)-A said he had no additional information or ability to calculate both potable and non-potable water usage in case of city water loss.	F 466	needed should the water from the normal water supply be compromised, an alternate source to procure water, and methods of distributing water throughout the facility. During the mandatory meeting July 21, 2015 the policy changes will be reviewed. Compliance will be monitored by the administrator during the routine annual interdisciplinary policy review.	

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	245153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2015**

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

Electronically Signed — 07/20/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Madonna Towers of Rochester is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V(111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building are a Type II(111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a V (111) building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 62 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 52 residents. Findings include: On facility tour between 12:45 and 3:45 PM on 06/29/2015, the review of the fire drill documentation for the past 12 months (July 2014 to June 2015) revealed that the drills for the following shifts were completed, but did not	K 050	Fire drills are held with sufficient frequency to familiarize staff with the drill procedures. Drills will be held once per quarter on each shift at no less than 1.5 hour intervals. A tracking log is being used to verify that fire drills are held quarterly on each shift and at unexpected times under varying conditions. The Environmental Service Director will be responsible for scheduling the fire drills to meet regulatory requirements. The administrator will monitor the scheduling of fire drills monthly for three months and randomly thereafter.	7/17/15

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K 050	Continued From page 3 sufficiently vary the times that the drills were conducted: Evening: 1530, 1501, 1800 and 1445 hours Night: 0445, 0530, 0500 and 0300 hours This deficient practice was confirmed by the Facility Environmental Services Director (JE) at the time of discovery.	K 050		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 52 residents. Findings include: On facility tour between 12:45 and 3:45 PM on 06/29/2015, documentation review for fire/smoke damper testing for the past 4 years revealed, that no documentation could be provided for the last 4 years period.	K 067	The maintenance staff has completed the required every 4-year test on the fire/smoke damper system. The test date was documented on the maintenance tracking log. A notice will be placed on the life-safety preventive maintenance checklist to remind the staff of the next required test of the fire/smoke damper system. The Director of Maintenance will be responsible for compliance.	7/17/15

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K 067	Continued From page 4 This deficient practice was confirmed by the Facility Environmental Services Director (JE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067		

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K 050	Continued From page 3 This deficient practice was confirmed by the Facility Environmental Services Director (JE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 10, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5153024

Dear Ms. Redalen:

The above facility was surveyed on June 29, 2015 through July 1, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 29, 30 and July 1, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 1 of 2 residents (R113) reviewed for admission, transfer, and discharge was provided with adequate notice of a room change. Findings include: R113's quarterly Minimum Data Set (MDS) dated 6/12/15, identified R113 had intact cognition. During interview on 6/29/15, at 6:59 p.m. R113 stated she had been in a different room when she was first admitted to the facility, but was told one day she had to move to a room on a different hall,	2 435	Corrected	7/31/15

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2 435	Continued From page 3	2 435		

adding "That kind of upset me." Further, R113 stated she would have liked to have had more notice so she could prepare herself to make the move. R113 stated, "I would have liked notice."

R113's progress note dated 6/11/15, identified R113 "...moved from [old room number] to [new room number] today. Social services will check in with resident next week on room adjustment." However, the progress note lacked any reason for the room change, nor any evidence R113 had been given notice prior to being moved.

During interview on 6/30/15, at 1:35 p.m. trained medication aide (TMA)-A stated R113 had changed rooms recently. Further, TMA-A stated the residents should be given notice before being moved. TMA-A stated, "Because we [staff] know about it", adding staff are aware of room changes "a couple days" before they occur.

On 6/30/15, at 2:21 p.m. registered nurse (RN)-A and licensed social worker (LSW)-A were interviewed regarding R113's lack of notice before having a room change. RN-A stated staff speak with residents and their family to determine if a room change is needed to determine "whatever is the best fit." R113 had not been making the desired progress with therapies, and was going to stay "longer term than expected" so she needed to change rooms off of the short term wing. RN-A spoke to R113 about the move "probably the day of, or the day after she moved." Further RN-A added she was unaware how much notice residents were typically given before having a room change, "I don't think there is a process." LSW-A stated she told R113 about changing rooms on 6/10/15. R113 had questioned when she would be moving, and was told "they [staff] are looking at tomorrow." R113 was unhappy

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2 435	Continued From page 4 with the lack of notice, "but accepted it." R113 had an appointment the following day, on 6/11/15, and requested to wait until after she had returned to move her belongings. However, when she was away at the appointment, staff had moved her belongings despite her wishes not too until her return from her appointment. LSW-A stated R113 was upset when she returned and found her belongings moved. Further, LSW-A stated R113's room change "probably could of" been handled differently, and added "we can always improve." A facility Room Change policy dated 01/2015, identified, "Residents have the right to be informed when there is a change in room. Residents will receive a 7 day advanced written notice regarding the room change." Further, the policy identified a procedure which included, "Social Services will provide coordination of the move by preparing the resident and responsible party for the move emotionally as well as assisting with the move of personal belongings." SUGGESTED METHOD OF CORRECTION: The facility could review room change notification policy, provide education, and develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing,	2 560		7/31/15

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2 560	Continued From page 5 and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plan interventions for bilateral leg skin problems for 1 of 2 residents (R74) reviewed for non-pressure related skin injuries. Findings include: R74 was admitted to the facility on 8/7/14, with diagnosis that included hip fracture, dysphagia, and dementia according to R74's undated care plan. During observations on 6/29/15, at 2:00 p.m., R74 was seated in a wheelchair in resident's room, dressed neatly. Observations at that time revealed R74 right leg calf covered in red areas from below the knee to the ankle and left leg from below the knee to ankle was covered in faded red areas. R74 stated did not know what the areas were on the legs. The facility identified R74 on the quarterly Minimum Data Set (MDS), an assessment dated 4/24/15, to have intact cognition, required extensive assist of one staff for activities of daily living, and had no other skin problems. Document review of R74's quarterly skin assessment dated 4/29/15, identified no pressure ulcers, no venous and arterial ulcers, and had	2 560	Corrected	

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2 560	Continued From page 6 open lesions other than ulcers, rashes, cuts, left temple skin cancer removed. Interventions included skin monitored two times a day with cares. Document review of R74's care plan problem, dated 8/31/14, directed staff R74 had alteration in skin integrity related to history of pressure ulcers, impaired mobility, risk identified on skin risk observation tool, advanced age, and history of skin impairment on right buttock. Interventions included pressure reduction mattress bed and cushion to chair, keep clean and dry, monitor skin with cares, follow up with wound nurse as needed, incontinent care, and reposition as indicated. The care plan did not address red areas on legs. During interview on 6/30/15, at 3:40 p.m., assistant director of nursing (ADON)/registered nurse (RN)-Q and RN-D verified neither had been aware of the reddened areas on R74's legs. RN-D verified the lack of documentation identifying reddened areas on legs. During interview on 6/30/15, at 3:45 p.m., nursing assistant (NA)-C stated R74 had the reddened areas on both legs for at least one month. NA-C stated had notified a nurse who then applied lotion to the legs. During interview on 6/30/15, at 4:00 p.m., RN-B stated was aware of the reddened areas on both legs and had applied triamcinolone cream to the areas, most recently on 6/27/15. RN-B stated not aware if the reddened areas had been evaluated by a physician. Document review of nursing assistant bath sheets revealed instructions to "Circle any parts	2 560		

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2 560	Continued From page 7 of the body below where you see: Bruises, redness/discolorations or darkening of skin, rash, open areas, skin tears or wounds." Review of bath sheets dated 6/26/15, hand written entry stated, "rash, Vanicream on ongoing rash." There was no indication of where the rash was located. Document review of physician orders with start date of 8/7/14, revealed orders for triamcinolone cream 0.1% apply thin layer two times a day as needed. The orders did not identify where to apply triamcinolone cream. Document review of physician orders dated 6/15/15, revealed orders for triamcinolone cream 0.1% apply thin layer two times a day as needed to rash on legs. Document review of facility medication administration record dated 4/1/15 to 4/30/15, and 5/1/15 to 5/31/15, revealed triamcinolone cream two times a day as needed, with a start date of 8/7/14, no indication of where the affected area was located, and none was documented as administered. A hand written note on the May medication administration record dated 5/11/15, revealed the cream was discontinued. Document review of facility medication administration record dated 6/1/15 to 6/30/15, revealed triamcinolone cream two times a day as needed to rash on legs with a start date of 6/15/15. Document review revealed the cream had been applied on 6/15/15, 6/27/15, and 6/30/15. During interview on 7/1/15, at 10:45 a.m., RN-Q verified R74 was admitted to the facility with ongoing bilateral leg rash. RN-Q verified R74's care plan lacked identification of ongoing bilateral reddened legs and staff instructions for care of the red areas. During interview at that time, RN-D stated had just talked with family member who stated R74 had rash on legs "on and off " for	2 560		

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2 560	Continued From page 8 years. Review of facility policy: Care Planning Process dated 8/2014: read on page 2, #4, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." "... Have treatment objectives with measurable outcomes." SUGGESTED METHOD OF CORRECTION: The facility could review current care planning policies, provide education on care plan development, design and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced	2 570		7/31/15

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2 570	Continued From page 9 by: Based on interview, and document review, the facility failed to ensure timely revision of the comprehensive plan of care to include a developed pressure ulcer for 1 of 1 resident (R4) reviewed for pressure ulcers. Findings include: R4's annual Minimum Data Set (MDS) dated 4/10/15, identified R4 had severe cognitive impairment, was at risk for developing pressure ulcers, but had no current pressure ulcers. During interview on 6/30/15, at 8:20 a.m. registered nurse (RN)-E stated R4 likes to wear her shoes, and obtained an unstageable pressure ulcer (full thickness tissue loss but the wound base is covered by slough or scabbing) as a result of the shoes. R4's Resident Progress Note dated 5/23/15, identified, "Resident c/o [complained of] pain in right foot this morning. Inspection revealed a small open area [pressure ulcer] surrounded by red, inflamed skin." A subsequent progress note dated 5/24/15, identified, "The sore [pressure ulcer] appears to have been caused by her shoe. A pair of gripper socks [soft socks used to reduce pressure] was applied and the resident was instructed to not wear shoes." During interview on 6/30/15, at 1:19 p.m. nursing assistant (NA)-A stated she was unaware of R4's pressure ulcer on her right foot or of any interventions that were being done for it. Further, NA-A stated staff check the resident care guide for updates, adding the care guide is created from the residents comprehensive care plan.	2 570	Corrected	

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2 570	Continued From page 10 R4's care guide, dated 6/29/15, identified R4 was a "LOW RISK" of skin breakdown. The care guide lacked any indication R4 had a current pressure ulcer on her right foot, nor any interventions for staff to follow to promote healing and reduce the risk of infection to the pressure ulcer. R4's care plan dated 4/30/15, identified R4 had "potential for alteration in skin integrity r/t [related to]; decreased mobility and new shoes 4/2015." The care plan lacked any indication of R4's pressure ulcer on her right foot nor any interventions for staff to follow to promote healing or reduce the risk of infection in the pressure ulcer. During interview on 6/30/15, at 2:06 p.m. NA-B stated R4 had no pressure ulcers "that I know of." NA-B stated she would use R4's care guide to locate interventions if she had a pressure ulcer, "We're always told to go by our care guide." NA-B stated it was "very important" the care guides are correct and up to date for R4. Further, NA-B stated R4 was not currently wearing her shoes because of swelling in her feet, not because of any skin concerns. When interviewed on 6/30/15, at 3:15 p.m. RN-B stated R4's care plan should have been updated to include her developed pressure ulcer and identified the intervention of leaving R4's shoes off to reduce the pressure on the skin of her feet. Further, RN-B stated the care plan is used "so we know how to care for our residents." At 3:40 p.m. RN-B approached the surveyor and stated she located R4's current comprehensive care plan, but added, "we don't see this." RN-B stated she had never been shown to access a residents care plan, but were told by the former director of	2 570		

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2 570	Continued From page 11 nursing (DON) to "just play around with the computer" and learn how to find it. Further, RN-B stated she would have liked education on how to change a residents care plan. During interview on 6/30/15, at 3:50 p.m. RN-C stated R4 developed a small pressure ulcer on the top of her right foot from wearing tight fitting shoes. The pressure ulcer was "unstageable" currently, and the intervention to reduce it and promote healing was to remove her shoes and wear gripper socks. Further, RN-C stated R4's care plan and care guide should have been updated to include the pressure ulcer and the current interventions for it. A facility Care Planning Process policy, dated 8/14, identified a care plan should be "periodically reviewed and revised by a team of qualified persons after each assessment." The resident care plan should describe, "Services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." Further, the policy identified the care plan should be "updated following any changes in status or as a resident condition/orders change..." SUGGESTED METHOD OF CORRECTION: The facility could review current care planning policies, provide education on care plan revision, design and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		

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21530	Continued From page 12	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		7/31/15

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21530	Continued From page 13 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to take action in regards to the consultant pharmacy recommendations for target behaviors for 1 of 5 residents (R95) reviewed for unnecessary medications. Findings include: R95 was admitted to the facility on 4/14/2015 according to the facility admission record and had diagnoses that included but not limited to senile dementia with delusions and behavioral disturbance. R95's physician orders provided by the facility on 7/01/2015 included the order for Zyprexa (antipsychotic medication) 2.5 milligrams (mg) in the morning and 5 mg in the evening before bed for senile dementia with delusions. April 2015 pharmacy medication regimen review communication form to the facility indicated the consulting pharmacist identified the absence of individualized target behaviors and monitoring. The pharmacist medication regimen review read, "...please be certain target behaviors have been clearly and specifically identified and are being monitored objectively and qualitatively..." The Medication Regimen Review chart form for May and June 2015 also identified the absence of target behavior identification and monitoring by the consulting pharmacist. Facility policy Antipsychotic Medication Use last revised 3/14 lacked specific direction on how to identify specific target behaviors and interventions and lacked direction on monitoring and timeliness of evaluation(s) for effectiveness and justification.	21530	Corrected	

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	00419	A. BUILDING: _____ B. WING _____	07/01/2015

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21530	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The facility could review their policy, design a process that ensures pharmacy recommendations are acted upon in a timely manner, and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by:	21535		7/31/15

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21535	Continued From page 15 Based on observation, interview, and document review the facility failed to identify target behaviors and monitoring effectiveness of the medication for 1 of 5 residents (R95) reviewed for unnecessary medication use and who was prescribed antipsychotic medication. Findings include: R95 was observed on 6/29/15, at 2:15 p.m. R95 was resting in bed awake, and stated, "Can you get in here and get to the door I have my boots on." R95 had socks on. R95 then reached out in front of her, opened and closed her hands repeatedly as if she was reaching or grabbing at something that was not there. As R95 reached/grabbed she stated, "Are you here, I'm not hiding, however we can transfer our stuff." R95 then put her head down, put her hands to her forehead and shook head gently back and forth and patted her forehead and the sides of her head as if she had a headache or was deep in thought. R95 then dropped her hands to her lap and continued to fidget. R95 was admitted to the facility on 4/14/2015 according to the facility admission record and had diagnoses that included but not limited to senile dementia with delusions and behavioral disturbance. R95's admission Minimum Data Set (MDS) dated 4/20/15 indicated severe cognitive impairment had not had behaviors during the assessment period, and an antipsychotic medication had been used. In addition the MDS revealed a PHQ-9 (mood assessment to determine signs and symptoms of depression) score of zero indicating no depressive signs or symptoms. R95's physician orders provided by the facility on 7/01/2015 included the order for Zyprexa (antipsychotic medication) 2.5 milligrams (mg) in the morning and 5 mg in the evening before bed for senile dementia with delusions.	21535	Corrected	

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21535	Continued From page 16 R95's electronic care plan provided by the facility on 7/1/2015. The care plan identified psychotropic drug use related to dementia with agitation and history of delusions however, did not identify individualized target behaviors and failed to define R95's delusions. The care plan included generalized interventions of "reapproach, different staff, offer food/fluids." In the absence of individualized target behaviors, it could not be determined when nonpharmacological interventions nor if Zyprexa was affective in relieving delusions. April 2015 pharmacy medication regimen review communication form to the facility indicated the consulting pharmacist identified the absence of individualized target behaviors and monitoring. The pharmacist medication regimen review read, "...please be certain target behaviors have been clearly and specifically identified and are being monitored objectively and qualitatively..." The Medication Regimen Review chart form dated 5/25/15 and June, 2015 again identified by the by the consulting pharmacist the absence of target behavior identification and monitoring. During an interview on 7/1/2015, at 10:52 a.m. licensed social worker (LSW)-A explained the LSW was responsible for creating the behavioral care plan and verified individualized target behaviors were not identified on care plan. LSW-A verified a comprehensive evaluation for medication effectiveness had not been completed since R95's admission. LSW-A stated the tracking on the computer completed by nursing assistants for behaviors and interventions were "generic" in nature. Facility policy Antipsychotic Medication Use last revised 3/14 lacked specific direction on how to identify resident specific target behaviors and interventions and lacked direction on monitoring and timeliness of evaluation(s) for determining if	21535		

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21535	Continued From page 17 nonpharmacological interventions and medication had been effective to justify the continued use of the antipsychotic medication. SUGGESTED METHOD OF CORRECTION: The facility could review and update psychotropic medication policy to include current standards for identifying and documenting target behaviors and interventions, design and implement a process for identifying, monitoring, documenting, and evaluation of target behaviors and interventions to ensure medication is effective and justifiable, and implement an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or	21545		7/17/15

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21545	Continued From page 18 (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 9 residents (R59, R29) received medication in accordance with physician orders and pharmacy instruction. This resulted in a facility medication error rate of 6.89% (percent). Findings include: R59's quarterly Minimum Data Set (MDS) dated 4/10/15, identified R59 had no cognitive impairment. R59's signed Physician Order	21545	Corrected	

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21545	Continued From page 19 Report dated 5/12/15, identified an order of, "aspirin tablet, chewable; 81 mg [milligrams]; oral ... once a day..." During observation of medication administration on 6/30/15, at 8:35 a.m. licensed practical nurse (LPN)-A prepared R59's medications at a mobile cart outside the dining room. LPN-A removed a white bottle of aspirin 81 mg and poured two pills inside a clear cup in addition with R59's other prescribed medications. LPN-A turned to leave the cart and administer the prepared medications to R59 who was seated in the dining room, and was stopped by the surveyor. LPN-A and the surveyor removed the medications from the clear cup and reviewed them identifying LPN-A had placed two aspirin in the cup when R59's signed physician orders called for one. LPN-A stated R59 should only have one aspirin and added, "I must have done it twice." R29's quarterly MDS dated, 5/14/15, identified R29 had moderate cognitive impairment. R29's signed Physician Order Report dated 5/28/15, identified an order of, "Flonase (fluticasone) [a nasal spray used to reduce inflammation] spray, suspension; 50 mcg [micrograms]/actuation; nasal ... 1 spray each nostril BID [twice a day]..." During observation of medication administration on 6/30/15, at 3:33 p.m. trained medication aide (TMA)-A removed R29's Flonase medication from a mobile cart by the nurses station and provided it to the surveyor for review. The label identified the correct medication, but further had a blue sticker affixed to it which read, "SHAKE WELL." However, TMA-A did not shake the vial of Flonase as instructed, and provided the medication to R29 who was seated in his room.	21545		

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21545	Continued From page 20 When interviewed after the administration of medication to R29 on 6/30/15, at 3:37 p.m. TMA-A stated she did not shake the Flonase as instructed, but should have "so it mixes the medicine." During interview on 7/1/15, at 10:47 a.m. LPN-B stated TMA-A should have shaken R29's vial of Flonase prior to administering it "to mix up the medication", as if not done the suspension of medicine "kind of separates." The medication is shaken well prior to administration "to make sure you get the correct dosage." Further, LPN-B stated nurses are taught to triple check orders prior to giving medication, and if R59 had been given two aspirin instead of the ordered one, it would lead to potential increased bleeding. When interviewed on 7/1/15, at 11:11 a.m. the director of nursing (DON) stated R59 should have only had one aspirin prepared for administration, and TMA-A should have followed the pharmacy instructions for R29's Flonase and shaken it prior to administering it. Further, the DON added, "I expect them [staff] to follow the Rights [" five rights " : the right patient, the right drug, the right dose, the right route, and the right time], of medication administration." When interviewed on 7/1/15, at 2:02 p.m. the consulting pharmacist (CP) stated R29's Flonase was a suspension and "should be shaken" prior to being given. Further, R59 should have only been prepared one aspirin according to her current physician orders, "that would be an error" had two doses been given. A facility Medication Administration by Licensed and Non-Licensed Personnel policy, dated 10/14, identified, "Medications are administered in	21545		

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21545	Continued From page 21 accordance with the written orders of the attending physician or nurse practitioner." Further, the policy directed staff to, "Read and follow any special instructions written on labels." SUGGESTED METHOD OF CORRECTION: The facility could review their policies on medication administration, provide education on medication administration, and implement an auditing system to ensure safe medication administration and ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure an environment was maintained clean and in good state of repair for 3 of 5 resident rooms reviewed. Findings include: An environmental tour was conducted with the maintenance manager (MM)-A and MM-B on 6-30-15 at 2:19 p.m. with the following findings:	21685	Corrected	7/31/15

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21685	Continued From page 22 Room C-120's wheelchair seat cushion is a light yellow foam, which did not have a cover around it. In the same room, the door to the hallway, frame/jam protector, is loose and falls off when touched. The bathroom wall has a scrape where the paint is scrapped off. The scrape was located a foot above the floor. Both MM-A and MM-B agreed these issues were a problem. In room C-123 the resident's wheelchair's left leg rest had torn and jagged vinyl with the padding exposed. Pieces of vinyl were also missing. MM-A and MM-B both agreed the vinyl is worn out and needs replacing. It was not a cleanable surface and was a safety risk. In room C-122, the wheel chair was dirty with a thick coat of dust type of material on the metal poles under the chair seat and also had food debris attached to the chair frame. MM-A and MM-B verified the dirty chair. An interview on 07/01/2015 at 7:13 a.m. with housekeeping staff (HS)-A stated the wheelchairs are suppose to be washed once a week. She said she attempts to wash the wheelchairs but there is no cleaning schedule. An interview on 07/01/2015 at 7:35 a.m. HS-B stated if i see a dirty chair I clean it. "I don't have a cleaning schedule right now, so I could miss a wheelchair." During an interview on 07-01-15 at 8:05 a.m. MM-A confirmed he is not aware of a cleaning schedule for the wheelchairs. He also stated there is not a maintenance or safety inspection process for the facility.	21685		

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21685	Continued From page 23 SUGGESTED METHOD OF CORRECTION: The facility could review and/or develop physical plant and resident equipment routine maintenance schedules and develop and auditing system to ensure safe clean working resident equipment, maintained home like physical environment, and ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685		