

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted November 17, 2020

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

RE: CCN: 245153 Cycle Start Date: October 23, 2020

Dear Administrator:

On October 23, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0806 was removed. However, continued non-compliance remains at the lower scope and severity of D.

#### REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2020, (42 CFR 488.417 (b)).

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

# SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Madonna Towers Of Rochester Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 23, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request

a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

# DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2021 (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.

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

# APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

## Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

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

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

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

# APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			'		APPROVED
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LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						11/24/2020

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

PRINTED: 11/25/2020

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F 585	and the date the wr (vi) Taking appropri accordance with St of the residents' rig or if an outside entii the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evi result of all grievant than 3 years from the decision. This REQUIREMEN by: Based on interview facility failed to ens call-light wait times resolution for 6 of 6 R13, R14, R15) rev complaints of assiss response time. Findings include: During document review for those 68 grievar length of time it too call lights. During document ref meeting minutes fro The meeting was at including R12, R13 included social wor administrator. Minu	itten decision was issued; ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less ne issuance of the grievance NT is not met as evidenced v and document review, the ure grievances related to long were acted upon for timely residents (R7, R11, R12,	F 58		rns ekly nt rns ekly nt l in nt rns ekly			

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					OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245153	B. WING		C 10/23/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPLÉTIO LE APPROPRIATE DATE
F 585	timely manner, wait concern if there wa too long for staff to reply read, "Shared doing to help staff a and shared that hut hard to recruit staff. identified in the min During document re meeting minutes fro identified) were rev attended by 15 resi R13, R14 and R15. SW-A and the curre indicated concerns the floor, especially p.m.; call lights beir answered, call light the toilet too long, s they are supposed plan of action to ad R12's quarterly Min assessment dated cognitively intact. D 10/19/20, at 10:58 a always come when adding, "Nothing m at night and it's dar stated, "They alway say 'I'll be right bac R12 stated, "I'll be right words; they don't co start out using my v but my kids say don	ting too long for help, and s an emergency, it would take respond. The administrator I what the team has been adjust to changes with Covid man resources is working ." No other plan of action was	F 58		R15 will be dit. t Madonna to be affected. s" policy was rent. All staff to erns and 4 Call system gs on 12/1 and heet has been t response time the associate PDCA and ased goal. d by 12/4/2020. 11/19/2020. ms and call light pleted 3x/week responsible for I be reported at meeting with iration to be

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00419

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## PRINTED: 11/25/2020 FORM APPROVED

		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		245153	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 585	about it. According minutes, R12 attend September 2020, m response time cond R14's quarterly Min assessment dated cognitively intact. D 10/19/20, at 1:13 p. my light on and wai prune juice and wh so I try and go by m on my own that I'm stated when long ca brought up at reside and the administrate changed the subject it." R14 stated, "It w allowed to say muc stated, "They say it but it's far from it." / meeting minutes, R 2020, meeting whe concerns were raise A grievance report for administrator talked The administrator e would be two peopl but when staff call i at the last minute. A education with staff	to resident council meeting ded the 7/31/20 and neetings where call light cerns were raised. nimum Data Set (MDS) 10/6/20 indicated R14 was During an interview on .m. R14 stated, "I can have it as long as 30 minutes. I take en I have to go, I have to go, nyself. I'm having to do things not supposed to do." R14 all lights and staffing were ent council, "It got a bit heated tor backed away from it and ct. He didn't want to talk about vas evident we were weren't th as he cut us off." R14 's supposed to be our home, According to resident council R14 attended the September re call light response time	F 5	585			

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY IPLETED
		245153	B. WING				C 23/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	IA TOWERS OF ROCI				4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Continued From pa answer lights.	ige 7	F٤	585	5		
	R13's quarterly Min assessment dated 9 cognitively intact. D 10/19/20, at 2:09 p. wait 10 minutes for "Today I waited 40 r "Personally, I have consequences of ha answeredyet." R1 resident council me response time was said, "We'll take car back from them." Ar meeting minutes, R September 2020, m response time conco A grievance report of reported her call lig answered: used to 1 20 minutes. The (pr to R13 and informe some changes with getting more people The administrator w understanding that full-time staff droppi return to school, bu everything they cou A grievance report of was upset due to ca this day. R13 indica problem and on this to waiting for some	aving to wait for call light to be 13 stated she attended betings where call light discussed and management re of that but we don't hear according to resident council R13 attended the 7/31/20 and neetings where call light cerns were raised. dated 7/31/20 indicated R13 ghts took too long to be be 10 minutes and now were revious) administrator spoke ad R13 that there would be n staffing with the goal of e on the floor at busy times. wrote that R13 was it was a hard time of year with sing to on-call or quitting to ut that the facility was doing					

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	2) MULTIPLE CONSTRUCTION BUILDING		TE SURVEY MPLETED
		245153	B. WING _		10	C / <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 585	were reviewed for & lights for R13, one (previous) administ would be some char goal of getting more times. The administ understanding that full-time staff dropp return to school, but everything they cou- same findings/follow 7/31/20, were adde 8/3/20. R7 During a telephone p.m. family membe SW-A that on 10/12 staff to respond to 1 bathroom. FM-F sta and told her R7 pus was responding. At facility and no one a p.m., FM-F's relativ one answered the p called R7 back and yet. At 6:51 p.m., F and a male answer R7's room. At 6:54 and still no staff we the phone with R7 room at 7:00 p.m." #2, but I think she f angry and frustrate and heart breaking and you can't help. the administrator of	age 8 3/3/20, and out of seven call was over 20 minutes. The trator informed R13 there anges with staffing with the e people on the floor at busy trator wrote that R13 was it was a hard time of year with ing to on-call or quitting to at that the facility was doing ald to recruit staff. NOTE: the w up for the grievance dated ed to this grievance dated ed to this grievance dated 2/20, it took over a half hour for R7's call light to go to the ated R7 called her at 6:30 p.m. shed her call light but no one t 6:37 p.m., FM-F called the answered the phone. At 6:40 ve called the facility and no phone. At 6:50 p.m., FM-F I learned staff had not arrived M-F called the facility again red who stated he would go to p.m., FM-F called R7 again re in her room. "I stayed on until someone came to her FM-F stated, "R7 had to go neld it." FM-F stated she felt d. FM-F stated she talked to in the phone about this on 20 and stated, "It was the	F 58	85		

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245153	B. WING	B. WING			23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	worst conversation being." FM-F stated just for R7, but for a heart breaks for the R7's admission Min assessment dated cognitively intact. D 10/20/20, at 4:48 p. lights to be answere stated she had soile ago. R7 stated, "Sta so long and leaders it but we don't see o R15's quarterly Min assessment dated a cognitively intact. D 10/20/20, at 4:27 p. couple of times whe minutes to be answ concerned there co and no one would k hour." R15 stated c been brought up at nothing changes. A meeting minutes, R September 2020, m response time conc During a telephone p.m. R15 told (FM)- minutes before staf FM-I stated, "Overa "R15 is frustrated a "R15 ended up mes	I've ever had with a human d, "We are speaking up not all the residents there, my em." himum Data Set (MDS) 10/11/20 indicated R7 was During an interview on .m. R7 stated waiting for call ed "makes me feel awful" and ed herself a couple of weeks aff don't explain why it takes ship says they will take care of changes." himum Data Set (MDS) 8/14/20 indicated R15 was During an interview on .m. R15 stated there had en call lights took 50 and 60 vered. R15 stated, "I'm buld be a medical emergency know it. A lot can happen in an call light response times have resident council meetings but according to resident council 815 attended the 7/31/20 and neetings where call light	F 5	585			

Facility ID: 00419

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		AND HUMAN SERVICES			FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY PLETED
		245153	B. WING			C <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	told FM-I that it take her to bed, that she supposed to. FM-I st concern when R15 but it was now. FM- her concerns. According to a griev FM-I called the faci had been long and be hired. FM-I expr hard when R15 new call lights were too grievance report, D for R15 from 9/14/2 over 20 minutes, of minutes and of thos DON noted she dis education was prov R11's quarterly Min assessment dated a moderate cognitive interview on 10/22/2 attended the Septe meeting stated resi response times, "bu gets better." During an interview (FM)-E stated, "R12 but no one comes, herself around." FM accidents (soiled he	es staff such a long time to put e transfers herself and was not stated, "She gets tired." FM-I	F 585	5		

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	time the time to hel like everyone else i call the facility to as just falls on deaf ea overwhelmed and s what's happening th A grievance report of reported waiting a l especially on 9/18/2 bathroom. It was no concern about fallin the bathroom. Griev documented by the R11's call lights for Of those 23, the gri six were over 20 r of those, four wer of those, four wer of those, three we of those, one was The grievance repor spoke to FM-E who she needed to use answering her call l facility to inform the with another reside station for help whe on for over an hour does not want certa contributing to long report indicated that not be scheduled o agreement with the During an interview nursing assistant (N	p herthey are understaffed is." FM-E stated, "I've had to sk them to help toilet her and it ars." FM-E stated, "They are sympathetic, but I don't know here." dated 9/18/20 indicated R11 ong time for call lights, 20, so she took herself to the oted that R11 expressed ng due to self-transferring to vance investigation findings b DON indicated a review of 9/18/20, and there were 23. ievance report indicated: minutes e over 30 minutes ere over 50 minutes a one hour and eleven minutes ort further indicated the DON o stated R11 called him to say the bathroom and no one was light, so FM-E called the em of this. The DON spoke int who went to the nurses' en she noticed R11's call light . Actions: R11 verbalized she ain staff working with her er wait times. Grievance at when able, those staff would on R11's hall and R11 was in	F 5	585			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			`́сом	E SURVEY PLETED
		245153	B. WING	i			C 23/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC				001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	baths on evening a less nursing assista residents and answ During an interview trained medication not aware of a speci lights were to be an say not longer than During an interview registered nurse (R the facility for two m telling him a time fra- be answered and a 20 minutes." During an interview DON stated it was to resident call lights to they have been wo assurance. DON st was longer than 15 we get a complaint is investigated." DC through call light log did, however she w During an interview administrator stated lights be answered Administrator admit call light logs; the q administrator was n call light responses he would ask reside	and weekends and this meant ants on the floor to assist ver call lights. / on 10/19/20, at 2:21 p.m. aid (TMA)-A stated she was cific time frame in which call hswered and stated "I would a 20 minutes." / on 10/19/20, at 2:57 p.m. RN)-C stated he has been at nonths did not recall anyone rame in which call lights should added, "not longer than 15 or / on 10/20/20, at 7:45 a.m. the facility goal to answer before 15 minutes, adding rking on this with quality tated she realized at times it is minutes. DON stated, "When about a call light response, it DN stated she has not looked gs, but their quality person /as on a leave of absence. / on 10/20/20, at 8:30 a.m. the d his expectation was for call	F	585			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE COMI	E SURVEY PLETED	
		245153	B. WING			C 10/23/2020		
NAME OF F	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MADON	NA TOWERS OF ROC	HESTER INC			1001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 585	Continued From pa	ige 13	Ft	585				
	(RN)-A stated call li answered in under assistants. RN-A st answered in 10 mir ask if they could an the NA needed help During an interview with administrator a call light grievances council meetings w administrator state it," adding, "the long meal times and had	y on 10/20/20, at 10:49 a.m. and SW-A, when asked how s brought up at resident ere addressed, the ed, "I was there and addressed g call light times were around d to do with Covid restrictions."						
	place to address th articulate the meas an action plan to ac times, administrato of action plans I can administrator stated	d it was hard for the facility to the change in leadership, but						
	related to resident of response times. Do 1. 7/27/20, quality a improvement (QAP notation regarding a on call lights, which satisfaction from 37 decrease call light r minutes will decrea 2. 8/24/20, QAPI m	provided quality documents grievances over long call light ocuments provided were: assurance and performance PI) meeting minutes with a brief an improvement team update n read: overall goal to increase 7.5% to 50%. Secondary goal: response times over 15 use from 17 out of 15. neeting minutes with a brief an improvement team update						

Facility ID: 00419

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TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	I	NO. 0938-03 3) DATE SURVEY COMPLETED
		245153	B. WING _		_	C 10/23/2020
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORT ROCHESTER, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	
F 585	on call lights which 50 % by 9/30/20. 3. 9/28/20, PowerF Monthly QAPI 9/28 and an action plan. specific steps, (e.g reduce call light res residents, reviewed June 2020, staff moverification these a response times had all action items had a new call light sys of 10/31/20. During an interview with DON and SW- more unhappy resi evidenced by an in stated she received families almost dail unhappy families a verbalized example members: 1) My m mom fell; what is th mom's portal and I and no one has co window and mom of stated she tried to therapy and got ba possible. According meetings with hum aren't getting applie burned out." DON stated, "Staff to do that day; noth	age 14 read: primary goal: 37.5% to Point presentation titled //20, included data measures . The action plan identified ., teach multiple ways to sponse time, interview d call light response times at eetings). There was no ctions to improve call light d occurred. The target date for d expired with the exception of tem, which had a target date / on 10/20/20, at 11:30 a.m. A, SW-A stated there were dents and families as crease in grievances. SW-A d voicemails and emails from lyThere are so many nd complaints." SW-A es of concerns from family om was left on the toilet 2) My he update? 3) I looked in see she ran a temperature ntacted me. 4) I went to her didn't eat her lunch. SW-A get a report from nursing and ck to family as soon as g to the DON, there are daily an resources and stated, "We cants and our current staff is stated staffing was taking all ng else was getting done. just get done what they have ning is being improved." DON provide the care residents	F 54	85		

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	`́сом	E SURVEY PLETED C
		245153	B. WING				23/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 585	deserve." DON ver light response polic light response time those periods could During an interview NA-B stated, "We're lights in 15 minutes stated there was no During an interview with corporate vice (VPO)-G and admir extensive grievance light response time medications not add concerns (incorrect The administrator s action plan to addre aware of all of the g residents, only thos The administrator s position in 2/2020, then clinical managers q rebuild the organiza During an interview SW-A stated grieva sources, interviews who came into her members, email, pf and in person. SW- an electronic custor was assigned to an corporate wanted th programs sends the	rified there was no facility call cy to indicate expected call for staff and what to do if d not be met. of on 10/20/20, at 4:45 p.m. e supposed to answer call s, 5 minutes preferably", but of enough staff to do that. of 00 10/22/20, at 11:07 a.m. president of operations nistrator, when asked about e reports which included call , change in baths schedules, ministered on time and food t food; food not warm enough). stated there was a call light ess call lights. VPO-G was not grievances and concerns of se that rose to a certain level. stated when he took the they had the state survey, n the DON was terminated and juit so have been trying to	F 5	85			

Facility ID: 00419

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLI	E CONSTRUCTION		E SURVEY
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING			IPLETED
		245153	B. WING				C
	ROVIDER OR SUPPLIER	243133	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	23/2020
	IA TOWERS OF ROC	HESTER INC		40	001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 585	this and reminded t complete it. Finding documented and ta Facility policy titled dated 2017, indicat Purpose was to cre resident and custor readily resolved. 1. A resident/reside to voice grievance a discrimination or re 2. The term "voice of formal, written griev include a resident's Concerns and griev anonymously. 3. The community of primary method to l	r delegate it. SW-A monitored he assigned person to is and follow up are lked about at QAPI. Concerns and Grievances, ed: ate an environment where ner concerns are solicited and nt representative has the right and concerns without prisal. concerns" is not limited to vance process, but may verbalization to staff. vances can be made views customer concerns as a earn of and meet customer eping with this belief, staff is d respond to resident/resident	F	585			
	<ul> <li>4. We do not tolerar</li> <li>5. We respect reside</li> <li>6. We encourage resemployees to raise</li> <li>7. The community a concern, there is a associates to acknow concern, investigate the resident appropriot toward resolution.</li> <li>8. The community significance officer.</li> <li>9. Residents and far admission of the community o</li></ul>	te retaliation. lent and employee rights.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON		HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	<ul> <li>10. When a concern completes a concern social services departed a concern social services departed a concern social services departed to an action pared to nation and opportunities for opportunity for impra. related procest probably cause idea b. an action plan is d. follow up rep quality council regarted.</li> <li>c. action plan is d. follow up rep quality council regarted.</li> <li>c. action plan is d. follow up rep quality council regarted.</li> <li>Facility policy titled 2017, indicated: Purpose was to promeet and provide a to listen and resport concerns.</li> <li>1. When a resident gracticable, in deverticable, in</li></ul>	n is voiced to staff, staff in form and forwards it to the artment. rocesses the concern. or and social services mpleted concern forms. oncerns is reviewed at the a is trended over time and al averages to detect patterns or improvement. If an ovement is identified: esses are reviewed and a ntified n is developed with timelines, and person(s) responsible implemented orts are presented at the rding effectiveness of the plan maintain evidence of esults of all grievance for a an 3 years from the issuance cision. Resident Council, dated vide for resident groups to forum of facility management ad to resident ideas and group exists, the facility roup views, and acts up the nmendations of the residents. y considers the group and attempts to accommodate	F 5	585			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		245153	B. WING		C 10/23/2020
AME OF PF	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	
ADONN	A TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	the resident group. 2. Minutes are mair provided, or access 3. The facility demo written requests/con council.	communicates its decision to	F 58	5	
SS=J	applies to all treatm facility residents. Ba assessment of a re- that residents recei- accordance with pro- practice, the compri- care plan, and the re- This REQUIREMEN by: Based on interview facility failed to mor condition, and failed for 1 of 1 resident ( blood clots in both I with a potential for the lungs). As a re- immediate jeopardy for R2 who had disp with significantly low requiring an increase transfer to the hosp	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered	F 684	<ul> <li>R2 is no longer in the facility. R8 is no longer in the facility. R9 is no longer in the facility. R9 is no longer in the facility.</li> <li>All residents on hospice, those with restrictions, and all those on oxygen the potential to be affected.</li> <li>"Change in Condition" policy was reviewed and remains current.</li> <li>"Benedictine Standing House Order: Symptom Management", which inclubowel management protocol was reviewed and remains current.</li> </ul>	have s for

Facility ID: 00419

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	SURVEY
	ST CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG _		0000	
		245153	B. WING				, 23/2020
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
MADONI	NA TOWERS OF ROC	HESTER INC			01 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 684	social worker (LSW infection prevention	/), culinary director, and hist were notified of the	F 68	34	Planning" policy was reviewed and remains current.		
	immediate jeopardy at 12:45 p.m. on 10/21/20. The immediate jeopardy was removed on 10/22/20 at 5:45 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy.				"Resident Examination and Assess policy was reviewed and remains of Licensed nursing staff, as part of the abatement plan, were educated or facility's Change in Condition polic emphasis on provider and response party notification and abnormal O2 and respiratory status. Licensed st	current. ne n the y with sible sats	
	assess for the use prevent constipatio who had a diagnos hospice for end of I and evaluate signs overload and follow residents (R9) with	a addition, the facility failed to manage, monitor, ssess for the use of bowel medications to revent constipation for 1 of 1 residents (R8), ho had a diagnosis of constipation and was on ospice for end of life care; and failed to monitor nd evaluate signs and symptoms of fluid verload and follow physician orders for 1 of 2 esidents (R9) with a diagnosis of stage 3 noderate) chronic kidney disease.			be educated on the facility's Chang Condition policy, Administering Medications policy, Comprehensiv Assessments and Care Planning p and the Benedictine House Standi Orders for Symptom Management nursing staff trainings on 12/1 and Licenses nursing staff, as part of the abatement plan, were educated or	ge in e policy ng at the 12/2. ne	
	Findings include: R2's admission Minimum Data Set (MDS) assessment dated 9/6/2020, indicated R2 had moderate cognitive impairment and required extensive assistance from two or more staff for bed mobility and transfers and required extensive assistance from one staff for toileting, hygiene, and dressing. The MDS indicated R2 had not required oxygen, was administered anticoagulant medications, and had a surgical wound. R2's Face Sheet, included diagnoses of acute embolism, deep veing thrombosis (DVT) of right lower extremity (added 9/14/2020), and atelectasis (lung collapse) (added 9/1/2020).				sign/symptoms of pulmonary embodility endotries of pulmonary embodility endotries of pulmonary embodility endotries of the emphasis on assessment and documentation of effectiveness of medications and use of electronic record BM report at the nursing states trainings on 12/1 and 12/. All nurses be educated on the electronic hear record Bowel and Bladder Observations (assessments) at the nursing staff trainings on 12/1 and 12/2. All nurses the section of	ated on nent PRN health aff es will lth ations	

Facility ID: 00419

If continuation sheet Page 20 of 105

TATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245153	B. WING _			C 23/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 684	following: Initiate a 1-4 I/min (liters per PRN (as needed) f breath), hypoxia (0 update provider with R2's care plan date experienced hyper identified to include ordered, check blo observe for signs of including; dizziness care plan did not a outlined in Require hospital Discharge vein thrombosis (A clots form in veins and PE (pulmonary which a blood vess by a blood clot). R2's hospital Discr dated 9/14/2020, h Issues Requiring F included, Continue lower extremity for swelling, evidence (diminished pulse, new/worsening pai weakness) and any breath, chest pain, suggest evidence of embolism. Please of stretch wraps daily as tolerated by pat	nd titrate supplemental 02 at minute) via nasal cannula for dyspnea (shortness of 2 saturation <90%); and to th nursing assessment. ed 9/11/2020, indicated R2 tension. Interventions were e administer medications as od pressure per order, and of high blood pressure s, chest pain, dyspnea. The ddress the instructions as ed Follow Up section of the Summary to monitor for deep condition in which the blood located deep inside the body) y embolism-A condition in sel in the lung(s) gets blocked harge Summary Brief Overview ad a section called, Active follow-up. This section close monitoring of the right propagation/worsening of of neurovascular compromise numbness/tingling, n in the distal extremity, y evidence of shortness of and/or hypoxemia that may of possibility of pulmonary wrap lower extremity with low for swelling control symptoms	F 68	respiratory status 5x/week for 4 v All residents are currently on cov monitoring including vitals with s respiratory monitoring. Audits for symptom recognition v completed 5x/week for 4 weeks v Electronic Medication Administra reporting function - "Facility Activ Report" which includes bowel movements, weights and fluid in Audits of nursing assistant docur for bowel movements will be con 5x/week for 4 weeks via point of documentation. Administrator/Designee is respon compliance. Results of monitoring shall be re the facility Quality Council meetin ongoing frequency and duration determined through analysis and of results.	id ats and <i>v</i> ill be with the tion ity ake. nentation npleted care nsible for ported at ng with to be	

		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` ´COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	lit [liter] per minute. continue to monitor skin assessment w coloration of right lo surgery 5 centimete R2's physician visit recapitulation of ho discharge orders for right lower extremit signs/symptoms of worsening DVT, an note indicated nurs need when working physical therapy re- oxygen for therapy shortness of breath tingling in the extre physician would co- increasing oxygen. bluish coloration of right leg. The note if sounds and "3. Nur monitoring of right I diminished/loss of p new/worsening pair weakness, shortnes and/or hypoxemia t pulmonary embolis R2's progress note increased to 3 lpm "Resident noted to subsequent note at	Call light within reach. Will "The note also indicated a as completed; purple blueish ower leg, edema +1. Scar from ers long. dated 9/15/2020, included spital admission and or active surveillance of the y, monitoring for pulmonary embolism, id oxygen requirements. The ing reported increased oxygen g with physical therapy, and quested order to increase sessions. Resident denied n, chest pain, numbness and mity. The note indicate the nsult with vascular clinic for Physical exam, skin: Purple right lower leg. Edema +1 included orders for ultra rsing will continue close lower extremity for swelling, oulse, numbness/tingling, n in the distal extremity, ss of breath, chest pain, that may suggest possibility of	Fθ	\$84			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 11/25/2020 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTIO		TE SURVEY MPLETED	
		245153	B. WING _			10	C 0/23/2020
NAME OF	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVEN ROCHESTER,	IUE NORTHWEST MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCED TO THE APPP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 22	F 68	4			
	"PT [physical therap in w/c [wheelchair] refusing it. Pt on ro to stand CGA [cont for 1 min [minute] w O2 and initially 92% decreased to 73% a rebound. PT donne Stood 2nd time and finger and decrease [seconds] of standid down. Vital machin cord retrieved to plu place O2 at 78% ar >90%. O2 increase time and watched O 20 sec and had pt s recover. Reassesse back to room air an quickly above >90. to room air w/ pt at of pt desaturation w give meds." R2's progress note a.m.stood with PT f let patient stand lor Donned oximeter a entire stand. After s to 81% after sitting therapeutic rest at 15 seconds only as and made pt sit dow	dated 9/16/2020, at 2:01 p.m. pist] found pt [patient] sleeping and didn't touch her lunch, om air and O2 SATS 95%. sit act guard assist] Pt stood v/ PT limiting time to assess % upon sitting and then and took about 1 min to ed O2 at 1 lpm and O2 93%. d able to place oximeter on ed to 66% after about 45 sec ng and had pt immediately sit e then had dead battery and ug in and by the time this took nd then quickly returned to ed to 3 lpm and pt stood 3rd D2 and decreased to 78% at stop. Pt took 1 min 20 sec to ed O2 SATS to do quick wean nd at [sic] was in 80's and Monitored to 2 lpm, 1 lpm and 100% by end. Notified nurse v/ activity as nurse arrived to dated 9/17/2020, at 11:39 for 1 minute, and PT would not nger to ass O2 sats/tolerance. fifer standing and O2>90% sitting, O2 eventually dropped for awhile and with 100%. Pt stood 2nd time and s O2 dripped to 85% quickly wn with O2 dropping to 74% to recover. Discontinued at this time.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COM	E SURVEY PLETED C
		245153	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	a.m. indicated R2 d breath and did not d down. A subsequer "PT just completed [treatment]: Pt foun on room air. O2 SA compared to L [left] on 3 lpm to increase increased to 95%. F wheeled walker] an 25 sec of standing at took 2 1/2 min to re going to stand pt ag use toilet urgently a transfer quickly to k rest prior to toilet tra decreased to 49% d notified nsg [nursing toilet and updated at toilet>w/c transfer v changing and clear to 39% with O2 on recover >90%. Nurs withheld. At rest in 60's to 100% while R2's clinic registered note dated 9/18/202 received from nurse Towers, Resident w when resident's 02 Room air sats were resident's 02 sats w oxygen 3L on, even no apparent distres cyanosis (bluish dis	dated 9/18/2020, at 11:13 lenied feeling any shortness of display symptoms when laying at note at 1:13 p.m. included, the following concerning tx d asleep in w/c w/ lunch tray, TS 84% on R [right] hand and hand at 80%. PT donned O2 e O2 SATSs for mobility and Pt stood CGA w/ FWW [front d decreased to 69% after just and had pt sit back down. Pt cover >90%. PT was not gain, however, pt requesting to and instructed pt on need to teep O2 SATS up. PT had pt ansfer CGA and O2 on 3 lpm. PT immediately g]. Nurse arrived while pt on and nurse stayed present for w/ CGA and dependent upon hing. O2 SATS then decreased 3 lpm and took 5 1/2 min to se to update NP and rest of tx w/c observed O2 SATS in mid	F	584			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	states they compar were getting the sa states readings were standing and sitting an S-bar be sent wiremains on 3L of 02 R2's follow-up physic at 1:43 p.m. include [name of nurse]. 02 place, at 3L was as certain of the accur Resident was just a and treated for DVT embolism, I gave of [hospital name] ED R2's physician note p.m. included "NP of reported that the ar assessed her and f They stated that sh to the ED. Nursing eye on her over the signs 3 times daily call if 02 drops <90 hospitalization) or if Assess for SOB [sh cough, dizziness/lig pain or swelling wh R2's progress note indicated the physic recommended send room for further eva services was called evaluated her and of	red with another machine and ime kind of readings. She re "all over the place" at g positions. Writer requested ith updated vitals. Resident 2. sician's note dated 9/18/2020, ed "Called facility and talked to 2 sat reading was all over the s low as 50% and they're racy of the equipment. admitted to [name of hospital] T. With concern for pulmonary rder to send her back to		584			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	and agreed to have closely over the we we are to send her R2's progress note R2 was seen by the that resulted in "Bila venous thrombosis R2's record lacked monitoring of the rig R2's physician visit indicated R2 was s The note included a section only include appears well-develo normal mood and a labs on next lab day close monitoring of R2's progress note included "Res [resid command. This AM body was very cold with extra blanket a oxygen was 56 eve Ambulance was ca to the hospital." The the physician had b saturation less than condition. R2's progress note family contacted the close to death.	e nursing staff "monitor her ekend. If any changes occur, in." dated 9/22/2020, indicated e doctor, had an ultra sound ateral non-occlusive deep is seen." documentation of further	Fθ	\$84			

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			СОМ	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC		4	1001 19TH AVENUE NORTHWEST		
	IA TOWERS OF ROC	HESTER INC		F	ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From par family member (FM had been at work a nurse at the facility indicated R2 may b room for non-emerg arrived at the facility around 6:00 p.m. th of sending R2 to the had ordered an incu- that on 9/25/2020, o was put up R2's no- resulted in not a hu amount, R2 also has stated R2's death c "Complications of ri- hypertension, and A On 10/21/2020, at 8 (DON) reviewed R2 and stated "the mor- respiratory status w inconsistent docum she was being used to ascertain worser DON stated on 9/28 R2's 02 saturations as well as the phys- for an hour. The DO have notified the fa when they were go participation in the o "progress notes and leave a lot of unans a lack of monitoring changes in color/wa	age 26 1)-A stated on 9/23/2020, she ind received a call from a before 4:00 p.m.; the nurse be going into the emergency gent cares. FM-A stated she y around 5:20 p.m. and he nurse told her that instead e ER, R2's vascular doctor rease in lovenox. FM-A stated once at the hospital a tube se to pump her stomach that ige amount of fluid but a good ad blood in her stools. FM-A certificate included, ight hip fracture-fall, Alzheimer's disease. 8:00 a.m. director of nursing 2's oxygen saturation records nitoring and assessing of vas lacking, there was hentation of how much oxygen d therefore would not be able hing respiratory condition." 5/2020, upon discovery of s, 911 should have been called ician instead of monitoring R2 DN also stated staff should mily member on 9/18/2020, ing to send her in to allow care plan. DON then stated d record are not complete and swered questions. There was g of the lower extremity for armth/sensation or color." y on 10/21/2020, at 3:03 p.m.		684	DEFICIENCY)		
	During an interview						

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	COM	E SURVEY PLETED C
		245153	B. WING	í			23/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC			4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	low oxygen saturati orders, place on ox physician dependent During an interview RN-B stated he was low oxygen saturati error in judgement called the physician The Immediate Jeo 10/22/2020, at 5:45 the facility provided competency testing the facility's change emphasis on abnor signs/symptoms of addition, the facility an auditing system R8 CONSTIPATION R8's significant cha assessment dated been admitted to he impairment, and did behaviors. Accordin extensive assistand members for bed m use. The MDS indid incontinent of bowe R8's Face Sheet, in bowel syndrome, co R8's care plan date "Resident has a ter receiving hospice s	ions, would check standing sygen and call 911 and/or nt upon situation. on 10/23/2020, at 5:03 p.m. s the nurse that found R2 with ions. RN-B stated it was an at the time and should have n and ambulance immediately. opardy was removed on 5 p.m. when it was determined d re-education and g to licensed nursing staff on e of condition policy with rmal respiratory status and pulmonary embolism. In o developed and implemented for respiratory monitoring. N: ange Minimum Data Set (MDS) 7/23/2020, indicated R8 had ospice, did not have cognitive d not have rejection of care ing to the MDS, R8 required ce from two or more staff nobility, dressing, and toilet cated R8 was always	F	684			

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		AND HUMAN SERVICES			FORM	: 11/25/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245153	B. WING			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 684	comfortable as able with hospice for end included, Administer monitor and docum medication. Follow- needed. The elimina 7/28/2020, indicated elimination related to opioid medication w s/sx [signs/symptom review date" (goal of interventions includ ordered and observ comfort/pain opioid bowel movement in protocol per standir Observe for s/sx of stools, abdominal b nausea and/or vom (6/29/2020) assist of to/from toilet. R8's physician order -Morphine concentr as needed (PRN) b needed for shortnes 7/18/2020, end date -Lactulose (laxative PRN for constipatio date 8/5/2020) -Lactulose 15 ml by take 15 ml daily as date 7/15/2020, end -Lactulose 30 ml tw end date 8/11/2020 -Senna with Docusa two tablets in the m	e with through collaboration d of life care." Interventions er medications as ordered, eent effectiveness of -up with hospice/provider as ation care plan edited on d R8 had alteration in to decreased mobility and with the goal of "will have no ms] of constipation through the dated 6/29/2020). The led, administer medications as // for effectiveness, see care plan (7/28/2020), If no n three days follow bowel ng orders (6/29/2020), constipation: passing hard/no oloating/swelling, cramping, iting, mental status changes of one stand pivot wheelchair ers included the following: rate solution 5 milligrams (mg) by mouth every hour as ss of breath or pain (start date e 8/9/2020) a) 15 milliliters (ml) once a day on (start date 7/15/2020, end // mouth daily and may also needed for constipation (Start d date 8/5/2020) //ice daily (start date 8/5/2020,	F 68	4		

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245153	B. WING		10	C / <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		10,2020
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	7/28/2020), order w take 3 tabs twice a 8/11/2020. -Bisacodyl 10 mg s (start date 7/19/202 -Bisacodyl tablet 5- date 7/15/2020, end -Bisacodyl tablet 5 date 8/5/2020, stop -Fleet enema 19-7 dose per standing of -Fleet enema one th constipation if no red date 8/2/2020, end Miralax 17 grams o 8/5/2020, end date Facility standing ord director on 3/1/2019 Management includ constipation; (Perfor rectal check to dete Bisacodyl supposite day for constipation Bisacodyl if no resu enema per rectum constipation mith (BMR), and progress record consistently bowel assessments physical examinatio distention, presence abdomen. The record medications were mited	vas changed on 7/28/2020 - day with a stop date uppository once a day PRN 20, end date 8/10/2020. 10 mg once daily PRN (start d date 8/5/2020) mg by mouth once day (start o date 8/11/2020) gram/118 ml; 1 tube, one time order (7/26/2020) ube, every three days PRN for esults from suppository (start date 8/11/2020) nce a day (start date 8/11/2020. ders signed by medical 9, for Bowel and Bladder ded the following for orm step sequentially) Perform ermine if impaction is present, ory 10 mg per rectum twice a h. Reattempt Senna or ults after 24 hours. Fleets every 3 days PRN for esults from suppository.	F 6	84		

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	R8 reported constip suppository and lax movement. R8's BMR identified movements on 7/23 One PRN dose of L 7/25/2020; dose wa effective, no further MAR indicated no F administered. R8's MAR on 7/26/2 administered a Flee special instructions order, with medium p.m. indicated R8 h and at 7:22 p.m. ha consistency of BM v BMR. R8's BMR included - 7/27/2020, mediur consistency identifie -7/28/2020, no bow -7/30/2020, no bow PRN dose of Lactul effective; no other in -7/31/2020, no bow	en. dated 7/22/2020, indicated pation "relieved with catives" had large bowel d R8 did not have bowel 3, 7/24, and 7/25/2020. .actulose was administered on as documented as not interventions documented. PRN suppositories were 2020, indicated R8 was ets enema, one time with : Day 4 no BM per standing results. The BMR at 1:22 had a large bowel movement d a medium bowel movement was not identified on the the following recordings: m bowel movement (no ed). rel movement rel movement, MAR indicated lose administered was not intervention. rel movement, MAR indicated pry administered day 4 no BM	F 6	84	DEFICIENCY)		
		l movement medium bowel movement that MAR indicated R8 was					

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED	
		245153	B. WING	-		C 10/23/2020		
	PROVIDER OR SUPPLIER	HESTER INC		40	REET ADDRESS, CITY, STATE, ZIP CODE 01 19TH AVENUE NORTHWEST DCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 684	administered PRN effective. -8/3/2020, no bowe suppository and lac not effective. -8/4/2020, medium soft/formed. MAR i Bisacodyl administ - 8/6/2020, no bowe Miralax was admin bowel medications -8/7/2020, no bowe scheduled medicat administered and of there was no bowe administered morp bottom pain 5/10; r effectiveness. -8/8/2020, small bo and hard; MAR ide for day 4 without a documented as effer record lacked evide re-approached. R8 mg at 2:58 p.m. for have bowel mover and at 4:58 p.m. for - 8/9/2020, 2 small (consistency was m R8 refused suppos - 8/10/2020, indicat stool, large loose s movement. R8's progress note "Resident complain Has no bowel mover	lactulose that was not el movement. PRN Bisacodyl ctulose administered and was bowel movement that was ndicated lactulose and ered and were not effective. el movement; MAR identified istered per schedule, no PRN administered. el movement; MAR identified ions given, Bisacodyl charted as effective although I movement recorded. R8 was hine 5 mg at 4:52 p.m. for ecord lacked evaluation of owel movement that was dry ntified Bisacodyl administered bowel movement; ective. R8 refused Senna S, ence after refusal R8 was was administered Morphine 5 discomfort when trying to nent and shortness of breath, r bottom pain.	F	684				

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	laxatives and Bisac Fleets enema giver Effective with medit verbalized relief wit note also indicated R8's progress note called to update on medication due to c R8's hospice visit n "patient received su digitally remove har no longer constipat small BM today. Bo quadrants, abdome discussed bowel re reports they will cor PRNs as the pt refu- laxatives at this tim and recommendation the nurse reported PRN Bisacodyl sup R8's hospice note co- indicated family me that pt is in significa- and pt is requesting note indicated hosp instructed the nurse Nurse reported that would be administe 12:15 p.m. the famil hospice that a supp with no results, the physician and obtai indicated the facility	a sper standing order. The mark stool. Resident h abdominal discomfort." The oral laxative encouraged. dated 8/3/2020, hospice not eating and need for bowel constipation. ote dated 8/3/2020, included uppository and nurse assist to rd stool. Patient reports she is ed and staff confirm she had a owel sounds active in to all four en soft and not tender. Writer gimen with facility nurse, who ntinue to monitor and utilize uses to schedule more e despite writer's education ons." The note also indicated the facility had been giving	F	\$84			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	indicated R8 report bowel medication s per hospice order w "PRN morphine giv transferring, and dis The note indicated visit and via phone management. A sul included, "STAT ver lactulose PRN per I placed." Note at 9: had a medium bow	dated 8/4/2020, at 1:09 p.m. ted constipation, scheduled suppository and enema given with small smeared results. ren for comfort during care, scomfort due to constipation." hospice was updated during	F	684			
	hospice at the facili Bisacodyl 10 mg da 30 ml twice a day. A p.m. indicated staff bowel movement du According to R8's M administered Morph rectal pain, record of effectiveness of the R8's progress note took her bowel and subsequent note at was applied to resid discomfort after bow	e medication. dated 8/8/2020, indicated pain medications. A t 8:47 p.m. indicated cream dents bottom due to					
	indicated hospice w	vas updated related to pain o discomfort with direction					

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	from hospice to star ordered. The note in the pain medication subsequent note at refused her morning member was prese administered includ "Resident started to involuntary constric muscles of the intes creating wavelike m contents of the can abdominal discomfo given hourly per oro management." The was contacted and R8's record lacked administration of bo initially refused. R8's progress note indicated R8 had a when she was repo R8's progress note (late entry documer p.m.) included, "Re [complained of] pain administered pain r anxiety. "This writer suppository to her r refusing oral bowel small bm's. Resider NO suppository." R room at the time an request. Hospice her	y on PRN medications as ndicated R8 was administered as and had good results. A 4:04 pm. indicated R8 had g medications. Family nt, asked medications be ling lactulose and senna. b have peristalsis (the tion and relaxation of the stine or another canal, novements that push the al forward) which caused ort and pain. PRN morphine der with less effect on pain note then indicated hospice increased morphine. staffs re-attempt of owel medications after it was dated 8/10/2020, at 5:51 a.m. soft small bowel movement sitioned. dated 8/10/2020, at 1:28 p.m. nted on 8/11/2020 at 1:40 sident restless and c/o n." Note indicated R8 was nedication and Haldol for	Fθ	\$84			

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			`́сом	E SURVEY IPLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	restlessness" the ne offer the suppositor refused. R8's hospice visit n "RN did rectal check rectal pain. [Name of practical nurse] did requested by this R refusal. RN noted p and disimpacted XL was unable to comp have bleeding from (possible hemorrhor rectal area to slow of pt Dulcolax suppos Bowel sounds hypo disimpacted, she w grimacing or restless note also indicated to hospice house. During an interview nursing assistant (N supposed to record sometimes things d think there was a w NA-D stated the nu sure residents had administer supposit every three days. During an interview NA-C stated NA's w bowel movements I indicated agency st NA-C indicated a su	age 35 ote indicated the nurse tried to by again and the resident note dated 8/11/2020, included k due to complaints of having of nurse] LPN [licensed not give suppository as RN on 8/11/2020 due to pt of to have hard stool in rectum L [extra large] hard stool. RN plete disimpactaction due to pt or rectum in moderate amounts oid). RN applied pressure to down the bleeding. RN gave itory to promote further BM. bactive x 4. After pt was ras able to relax with no facial ssness noted in bed." The the resident was transferred it on 10/21/2020, at 8:51 a.m. NA)-D stated NA's were bowel movements, didn't get charted, and didn't vay to look back at the history. Irses were supposed to make bowel movements and tories if they didn't have one	F	584			

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	movement every th nurse to administer During an interview licensed practical n were supposed to c and report to the nu- movement in 3 day constipation. LPN-A with nurses prior to an assessment to b physician's orders as medications. If a bo effective, then more During an interview registered nurse (R movement report sl was supposed to be no bowel movement suppository was sup indicated if it was n follow-up was supp stated a complete b completed prior to t medications and/or complain of constip During an interview registered nurse (R assessment should documented prior to laxatives. RN-C ind in three days suppo if there was not res needed to be comp documentation is no	ree days; that it was up to the the suppository. on 10/21/2020, at 9:34 a.m. urse (LPN)-A stated NA's document bowel movements urse if haven't had a bowel s or if resident complained of A stated TMA's have to check holding any medications for be completed. LPN-A stated should be followed for bowel owel medication was not e follow-up was required. on 10/21/2020, at 12:16 p.m. CN)-A stated there was a bowel heet. RN indicated the report e pulled up during the shift; if nts in 3 days then a pposed to be given. RN ot effective then more osed to be completed. RN powel assessment should be the administration of bowel when a resident would pation. of 010/21/2020, at 3:03 p.m. CN)-C stated a complete bowel be completed and of the administration of licated if no bowel movement posed to get a suppository, and ults then more intervention	F	584			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	`́сом	E SURVEY PLETED
		245153	B. WING	i			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	a standard for size it was left up to the determine difference small/medium/large During an interview director of nursing ( and confirmed phys management were nursing should have per physician order documenting refusa administer, if a TM/ should have reporte what happened. DO should be complete constipation and/or medication. During a return pho at 3:30 p.m. with nu stated staff should I medications per ord enema should not b prescribed medicat expectation that nu assessments daily concerns and befor medications. R9 FLUID OVERLO R9's admission Min assessment dated 9 not have cognitive i extensive assistant	documentation and indicated person recording to be between a. on 10/23/2020, at 7:42 a.m. (DON) reviewed R8's record; sician orders for bowel not followed. DON stated e followed the bowel regimen rs. DON stated they should be als and need to re-attempt to A documented refusals they ed to a nurse and document ON stated bowel assessments ed when complaints of before administering a PRN one interview on 10/29/2020, urse practitioner (NP)-B, NP-B be administering bowel ders. NP-B indicated fleets be given before using the tions. NP-B stated an rrses complete full bowel if there was constipation re administration of as needed	F	684			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	MDS also indicated administration of a assessment period R9's Face Sheet, ir hypertension, veno the liver (scarring o disease stage 3(mo rheumatic tricuspid heart's tricuspid val secondary pulmona R9's nutrition care p identified R9 was o interventions includ fluids, bowel mover applicable each shi low intake and refus R9's Hospital Disch Overview dated 9/2 hospitalized related blood loss. The sec Follow-Up included consider starting To 10 milligrams (mg) levels. R9's physician orde -Check heart rate, b (oxygen saturations requirement) Speci clinic staff] if SBP (s or SBP <90, HR (he <90% or increased other concerns (sta 10/2/2020)	d R9 received one diuretic during the 	F	584			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245153	B. WING				C 2 <b>3/2020</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	instructions: Notify   (systolic blood press (heart rate) >100 or increased oxygen in concerns. For heard if symptomatic (dizz syncope (start date 10/5/2020) -No added salt diet. restriction (start date -Weight daily before scale. Notify provide (pounds) or <261 lb -Torsemide 10 millig daily in the morning -Apply low stretch v extremities, on in th (start date 9/28/202 R9's vital sign recon identified heart rate the physician had b 9/21/2020, 11:49 a. 9/22/2020, 2:59 p.n 9/22/2020, 5:1 p.n 9/22/2020, 7:28 p.n 9/22/2020, 7:28 p.n 9/24/2020, 10:26 p. 9/25/2020, 7:34 a.n 9/26/2020, 9:48 a.n R9's 24 hour fluid ir lacked documentati	en requirement) Special [name of hospital staff] if SBP sure] >160 or SBP <90, HR <60, Sp02 <90% or needs, or with any other t rate <60 only notify provider ziness/lightheadedness or 10/2/2020, stop date . Special instructions <1.5 fluid te 9/21/2020) e breakfast. Use the same er if weight gain >267 lbs. os. (start date 9/28/2020) grams (mg) now and then t (start date 9/28/2020) wraps to bilateral lower the a.m. and off in the p.m. 20) rd was reviewed; the record is under 60 without evidence the notified. m. HR 55 n. HR 55	F	\$84			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DA	. 0938-039 TE SURVEY MPLETED
				ING		С
		245153	B. WING		10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODI 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETIO DATE
F 684	R9's daily weight re- revealed R9 had no days: -9/22/2020, wt. (we -9/23/2020, wt. not -9/24/2020, wt. 256 -weight not taken o 9/29/20. -9/30/2020, wt. 274 -10/1/2020, wt. not -10/2/2020, wt. not -10/3/2020, 276 lbs -10/4/2020, 276 lbs -10/5/2020, wt. not -10/6/2020, wt. not -10/6/2020, wt. not -10/6/2020, wt. not -10/6/2020, wt. not R9's record lacked monitoring and eva edema (swelling ca accumulation in the evidence R9's phys increased weight to R9's progress note- revealed the follow - 9/21/2020, include (pressure applied to of 0-2 millimeters (ri immediately) pitting extremities, with wr encouraged to elev -9/22/2020, include time. - 9/28/2020, include	ecord from 9/22/20 to 10/6/20 of been weighed 10 of the 15 eight) 264.7 lbs. taken 5.3 lbs. In 9/25, 9/26, 9/27, 9/28, or 4.2 lbs. taken taken taken s. taken taken taken s.	F	584		

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
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F 684	note indicated the p daily in morning an- bilateral lower extre- at night, ordered lal patient daily in fasti the same scale. -10/1/2020, at 1:09 diastolic pressure a symptomatic. SBAF done. A subsequen R9 had 3+ pitting e -10/2/2020, at 2:29 pitting edema in bo -10/3/2020, indicate confusion, urinary f SBAR was complet urine test. -10/4/2020, indicate and had increased called, physician di report any increase decreased intake, f test done right now -10/5/2020, indicate night and would foll -10/6/2020, include her provider this mo and needing diures send resident to em R9's progress notes	<ul> <li>bysician ordered Torsemide d apply low stretch wraps to emities, on in the morning off bs for 10/1/2020, and weigh ing state every morning using</li> <li>p.m. indicated R9 had low and heart rate less than 60 and R (a communication tool) at note at 2:29 p.m. indicated dema in both legs.</li> <li>p.m. indicated R9 had 3+ th legs.</li> <li>ed R9 was having increased frequency and yelling out, ted and faxed for request for</li> <li>ed R9 continued to yell out confusion, physician was rected to closely monitor and ed signs of confusion, fever, and did not want a urine</li> </ul>		\$84			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			COM	E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 684	revealed the followi -9/28/2020, R9 had evaluation of hyper "the patient has an target range of 261, not been weighed s weight at that time y indicated her blood low, usually 90's sy diastolic. The visit in started related to hy labs were ordered, week. -10/1/2020, at 9:00 weight parameters less than 261 lb or [skilled nursing faci has been very incom have been recorded not been weighed a today and up to this documented in EMI have made 3 separ for today's weight. I nurse at Madonna included, "Patient d extremity edema, w Her legs are curren indicated the plan w	ysician orders. es from 9/28/20 to 10/6/20 ng: a telehealth visit for tension. The note included order for daily weights with a -267 lb. unfortunately she has since 9/24/2020 and her was 256.3 lb." The note also pressures had been running stolic over 50's to 60's ndicated the Torsemide was yponatremia (low sodium), plan to follow-up later that a.m. "Patient does have to notify provider if weight is greater than 267 lb. SNF lity] documentation of weight nsistent. The weights that d are quite variable. She had at the time of my video visit s point, there is nothing R [electronic medical record]. I ate attempts to contact SNF have been unable to get a Towers." The note also oes report bilateral lower vorse in the right than the left. tly wrapped." The visit note vas to continue Torsemide for pred labs for 10/6/2020, and	F	584	· · ·		
	follow up next week						

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
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MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Initially she was wo way to the bathroor again at 11:15 a.m. not log on at 11:15. nursing was ready however, nursing w to call Madonna Tor nurse. Of note patie tomorrow, can addi time, if nursing sign -10/6/2020 "I had a yesterday for [name symptoms. Nursing with virtual video." today. At time of vis unable to answer q her need to urinate "Per nursing staff [r unwell and weak to has been confused experiencing urinar states that her eyel note indicated R9 v and did not know w note indicated the p transfer to emerger condition. During an interview NA-C stated NA's to however, it didn't al were busy in the m weight then the bat the weight on the re	orking with therapy and on her m. Nursing agreed to meet me to see patient. Nursing did Received page later stating for me to see patient, vas not signed on. Attempted wers, but could not reach a ent is scheduled for follow-up ress UTI symptoms at that as onto virtual visit. " ttempted to see the patient e of person] concern of UTI g was unavailable to assist Therefor the patient was seen sit she appeared lethargic and uestions other than to voice ." The note also included, name of nurse] patient is oday, [name] states that patient for two days and has been ty frequency. [Name] also ids appear to be swollen." The vas alert to person and year where she was located. The ohysician gave an order to ney room for decline in		584			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
MADONN	A TOWERS OF ROC	HESTER INC		4001 19TH AVENUE N ROCHESTER, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	stated she did not t and it would be imp condition. During an interview director of nursing ( and confirmed weig order, lack of edem and the physician w rate was below 60 p documentation did for symptoms for lo During a return pho at 3:30 p.m. with nu stated completing of been an ongoing pr were given set para physician and they directions on obtain morning, before bre NP-B indicated that get the appropriate monitoring and ass fluid balance, and s A facility policy/prot was requested and Facility policy Chan included "When a s resident's physical, status is identified t there is need to alte licensed nursing as attending provider a	A daily with weight. LPN-A hink it was being documented, portant to identify a change in a non 10/23/2020, at 7:42 a.m. (DON) reviewed R9's record ghts were not obtained per ha monitoring and evaluation, vas not notified when heart per the order. DON stated the identify if R9's was assessed over heart rate. One interview on 10/29/2020, urse practitioner (NP)-B, NP-B daily weights at the facility has roblem. NP-B stated residents ameters on when to notify the were also given specific hing daily weights in the eakfast, using the same scale. t in order for the resident to treatments nursing had to be essing for changes in weight, swelling. cocol for fluid management not received. mental, or psychosocial by the licensed nurse, or when er treatment significantly, the asociate consults with the	F 68	4			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	A TOWERS OF ROCI	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	in condition. A facility policy/prote was requested and Facility policy Admini included; To admini safe and accurate r rights of medication are administered in 3. Medications are a prescribed time. An destroyed and docu instruct to re-attemp Facility policy Chan included "When a s resident's physical, status is identified b there is need to alter licensed nursing as attending provider a resident/resident re not specifically defin in condition.	ne what constitutes a change cocol for bowel management not received. nistering Medications 2/2019, ister resident medications in a manner that will ensure the 6 n administration. Medications accordance with the orders. administered within their ny refused medication is umented as a refusal (did not pt). nge in Condition dated 2/2019, significant change in the mental, or psychosocial by the licensed nurse, or when er treatment significantly, the sociate consults with the and notify the presentative. The policy did ne what constitutes a change	F 6		DEFICIENCY)		
F 688 SS=D	CFR(s): 483.25(c)( §483.25(c) Mobility. §483.25(c)(1) The f		F 6	88			12/4/20
	range of motion unl condition demonstra of motion is unavoid						
	§483.25(c)(2) A res	sident with limited range of					

Facility ID: 00419

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245153	A. BUILD B. WING			(	
	PROVIDER OR SUPPLIER	HESTER INC	STREET ADDRESS, CITY, STATE, ZIP COD 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 688	services to increase prevent further dec §483.25(c)(3) A res receives appropriat assistance to main the maximum pract reduction in mobility unavoidable. This REQUIREMEN by: Based on interview facility failed to ens services to meet th residents (R11, R12 restorative services Findings include: R13 R13's face sheet pr diagnoses of ataxia coordination) and d system (loss of func- the spinal cord). R13's quarterly Min assessment dated cognitively intact, h vision, clear speech clear comprehensio assistance of one s toileting, and locom Walking in her room once or twice.	propriate treatment and e range of motion and/or to rease in range of motion. dident with limited mobility the services, equipment, and tain or improve mobility with cable independence unless a y is demonstrably NT is not met as evidenced w and document review, the ure staff provided restorative e assessed needs for 3 of 3 2, R13) reviewed for	Fθ	588	R11's care plan was reviewed and revised. R12's care plan was reviewed and revised. R13's care plan was reviewed and revised. All residents with restorative plans the potential to be affected. All restorative plans were reviewed care plans revised as necessary. "BHS Restorative Program" policy reviewed and remains current. All nursing assistants will be educa the documentation of restorative pl the nursing staff trainings on 12/1 a 12/2. Audits of completion of restorative and accompanying documentation completed 3x/week for 4 weeks. Administrator/Designee is respons compliance. Results of monitoring shall be repo	have I and was ited on ans at and plans will be ible for	

Facility ID: 00419

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		E SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G	` ´CON	IPLETED	
		245153	B. WING			C 23/2020	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	DE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 688	nursing dated 3/25/ restorative program (disease of nerves) the nervous system Goals and approace continue to ambula NuStep (stationary between 6:00 a.m. R13's point of care frequency of restory walking. The report zero times between times, the report lis Other reasons inclu assess, deferred du and unknown. During an interview R13 stated when the was able to use the but now that they w happening. R13 stather if she wanted to R13 admitted she sto to the small stature feel safe with them confident in the abi restorative services of money to be here meeting my needs. brought up at reside management is mo bottom line then the was not able to tell	<ul> <li>/20, indicated R13 required n to address neuromyopathy and degenerative disease of n with decreased mobility.</li> <li>thes indicated R13 would te 150 feet daily and use the bicycle) 10 minutes daily and 2:15 p.m.</li> <li>history report indicated the ative nursing related to t indicated R13 ambulated n 9/21/20 and 10/22/20. Three ted the reason as "refused." uded: not observed, could not ue to condition, unavailable</li> <li>/ on 10/22/20, at 12:45 p.m. hey had a restorative aid, she e NuStep and walk in the hall, vere short staffed, this was not ated only two staff have asked o walk in the past six weeks. sometimes refused to walk due of some staff, as she doesn't . R13 stated she was not lity of staff providing s. R13 stated, "I'm paying a lot e and they aren't always " R13 stated this has been ent council, "but the new ore concerned about the e residents." R13 stated she if the lack of restorative ed her, but expressed concern</li> </ul>	F 68	8 the facility Quality Council meetin ongoing frequency and duration determined through analysis and of results.	to be		

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	`́сом	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	R12 R12's facesheet pri diagnoses of Parkir affecting movemen debility, osteoporos brittle), muscle wea R12's quarterly Min assessment dated cognitively intact, h impaired vision req speech, was under comprehension. R1 assistance of two s and toileting, and re of one for dressing, locomotion on the u R12's care plan cat nursing dated 3/24/ restorative program disease with muscl approaches indicat ability to ambulate 2 for 10 minutes daily p.m. R12's point of care frequency of restora walking. The report feet daily during the seven times betwee only one time did sl report listed the rea reasons included: r	inted 10/23/20, indicated nson's disease (disease t), age-related physical sis (bones become weak and akness and repeated falls. himum Data Set (MDS) 8/18/20, indicated R12 was ad adequate hearing, uiring corrective lenses, clear stood and had clear 12 required extensive taff for bed mobility, transfers equired extensive assistance , walking in her room and	F	588			

Facility ID: 00419

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245153	B. WING	÷			C 23/2020
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	During an interview R12 stated, "If they doing good, and I d every day and I'm r rate. I'm not active of not using the NuSte "they didn't renew t no one to sit with yo she would like to wa that in the morning, could walk and staff comes." R11 R11's facesheet pri- diagnosis of demen- debility, osteoarthrif and muscle weakne R11's quarterly Min assessment dated a moderate cognitive hearing and vision, understood and had required extensive mobility, transfers, f and off the unit. R1' of one when walkin the corridor with as twice. During an interview R11 stated she war have time." R11 sta stated she could no helped her walk.	on 10/22/20, at 1:31 p.m. walk me once a week, I'm o need it. I'm getting weaker not going to last long at this enough." R12 stated she was ep at all anymore, adding hat gal's contract so there is ou while you do it." R12 stated alk in the hallway. R12 stated she would ask staff if she f say, "later, but later never nted 10/23/20, indicated tia, age related physical tis (wearing down of bones) ess. imum Data Set (MDS) 8/11/20 indicated R11 had impairment, had adequate	F	688			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	COM	E SURVEY IPLETED
		245153	B. WING				C 23/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	<ul> <li>p.m. family membedoing very well. FM the time to help hereveryone else and could not confirm if doubt it, but I just de "They're overwhelm don't know what's here and a state and a state a s</li></ul>	r (FM)-E stated R11 was not I-E stated, "To get them to find rthey're understaffed like they don't have time." "FM-E R11 walked daily stating, "I on't know." FM-E stated, ned and sympathetic, but I happening there." tegory called restorative /20, indicated R11 required n to address neuromyopthay ess and pain from nerve nritis of both knees, and spread muscle pain) with . Goals and approaches d continue to ambulate 400 he NuStep 10 minutes daily	F	588			

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	things I couldn't do. able to provide rest who require it, such know it's not getting staff or the time to or restorative services stated, "They'll deck them." During an interview (NA)-C stated she h residents who are or stated "something h NA-C acknowledge were important for the balance and streng brought this to the a DON stated they we staff. NA-C stated they aide, but that position nursing assistants a restorative services their other responsi During an interview DON stated she ha assistants to compliit in the electronic n moving on to the new was important so th care history report a some nursing assist documenting these acknowledged the s facility and stated s interventions, such not being done. DC	"When asked if staff were corative services to residents a swalking, NA-B stated, "I g done. We don't have the do it." When asked how lack of s might affect residents, NA-B line and that's not fair to on 10/21/20, at 8:42 a.m. had not been able to walk on restorative programs and has to give; we can't do it all." ed that restorative services residents stating, "it helps with th." NA-C stated she had attention of the DON and the ere working on hiring more hey used to have a restorative on was eliminated and now all are expected to provide s, such as walking, along with	F 6	\$88			

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TATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245153	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	-	/23/2020
	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 688	restorative services to the care plans. I staff about whether done, some nursing doing it, some said and some said they stated it was the ex- services as indicate acknowledged ther During an interview corporate vice pres- stated, "in this indu challenged, we are to meet the needs of stated there was a and stated, "it's unf allowed to go." VPC meet resident needs staffing and how ex- adding "leadership providing guidance reported they did n who are on a restor are too busy, VPO- of some issues unt Administrator adde the facility with Cov- staff quitting, and tr staff some pretty go concerns were mor Facility policy titled 2017, indicated: Purpose: To ensure comprehensively a restorative needs.	were being done according OON stated when she asked restorative serves were being g assistants said they were they didn't have time to do it, / forgot to document it. DON apectation staff provided ed on care plans, but e wasn't enough staff to do it. / on 10/22/20, at 11:07 a.m. ident of operations (VPO)-G stry, we are all staffing trying to ensure we have staff of our residents." VPO-G culture issue at this facility fortunate where it's been D-G stated not being able to ls, was a combination of short disting staff was working, needed to be on the floor and ." When informed staff ot have time to walk residents rative programs because they G stated she was not aware if they rise to a certain level. d that a lot had happened at rid19, changes in leadership, ying to rebuild, adding "we bod ratios" and resident care re related to staff inefficiencies. Restorative Program dated	F 6	88		

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		245153	B. WING		10	C //23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 688	each resident can a physical, mental an Restorative nursing highest level of inde including daily living and bed mobility. 2. A registered nurs program to ensure are being implement Sufficient Nursing S CFR(s): 483.35(a)( §483.35(a) Sufficie The facility must has the appropriate cor- provide nursing and resident safety and practicable physical well-being of each resident assessment care and considerin diagnoses of the fa accordance with the at §483.35(a)(1) The by sufficient number types of personnel nursing care to all r resident care plans (i) Except when was this section, license (ii) Other nursing po- limited to nurse aid §483.35(a)(2) Except	attain and maintain highest ad psychosocial well-being. g care promotes resident's ependence in activities g, range of motion, ambulation se will provide oversight to the the restorative interventions inted as planned. Staff 1)(2) int Staff. ave sufficient nursing staff with inpetencies and skills sets to d related services to assure attain or maintain the highest attain geschosocial resident, as determined by ints and individual plans of ing the number, acuity and cility's resident population in e facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with : ived under paragraph (e) of ed nurses; and ersonnel, including but not es.	F 688			12/4/20	

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED		
		245153	B. WING			C 23/2020		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP				
MADON		HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 725	nurse on each tour This REQUIREMEN by: Based on interview facility failed to ensi and meet the asses (R11, R12, R13, R1 lack of sufficient sta sufficient staff had t residents who resid Findings include: R12 R12's facesheet, pr diagnoses of Parkir affecting movement debility, osteoporos become weak and I repeated falls. R12's quarterly Min assessment dated a cognitively intact, ha impaired vision requision requision requision requision requision requision requision requision R1 assistance of two si and toileting, and eit dressing, walking in the off the unit. R12's care plan goa would reach maxim and improve ability living (ADL's) for ba- oral care. The care	of duty. NT is not met as evidenced and document review, the ure sufficient staff to provide sed needs for 4 of 4 residents (4) who voiced concern with affing in the facility. The lack of the potential to affect all 50	F 7	<ul> <li>R11's care plan was reviered.</li> <li>R12's care plan was reviewed.</li> <li>R13's care plan was reviewed.</li> <li>R13's care plan was reviewed.</li> <li>R14's care plan was reviewed.</li> <li>All residents who reside at Towers have the potential "Resident Rights and Notifiwas reviewed and remains." Comprehensive Assessme Planning" policy was revieremains current.</li> <li>"Concerns and Grievances reviewed and remains current." Concerns and Grievances reviewed and remains current.</li> <li>"BHS Restorative Program reviewed and remains current." BHS Restorative Program reviewed and remains current is completed for call light restorative plans were reare plans revised as neces All licensed staff will be ed Comprehensive Assessme Planning policy at the nurst trainings on 12/1 and 12/2 All nursing assistants will be statement will be statement with the statement proces of the statement were reare plans revised as neces and the statem</li></ul>	ved and ved and Madonna to be affected. ication" policy current. ents and Care wed and s" policy was ent. " policy was ent. " policy was ent. " policy was ent. " policy was ent. as been ponse time that associate PDCA and used goal. d by 12/4/2020. 1/19/2020. eviewed and essary. ucated on the ents and Care ing staff			

Facility ID: 00419

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED	
		245153	B. WING			2	
NAME OF F	PROVIDER OR SUPPLIER	240100		STREET ADDRESS, CITY, STATE, ZIP CODE	10/23/2020		
				4001 19TH AVENUE NORTHWEST			
MADONN	A TOWERS OF ROC	HESTERING		ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 725	Continued From pa	ide 55	F 72	5			
		and ambulation. Staff	1 72	the documentation of restorative	plans		
		se activities were identified as		and the use of the bathing prefe			
	nursing assistants a	and nurses.		form at the nursing staff training and 12/2.	on 12/1		
		on 10/19/20, at 10:58 a.m.		All nursing staff will be educated			
		as "not enough staff." R12		Resident Rights and Notification			
		always come when she puts I stated, "Nothing makes you		the Concerns and Grievances po BHS Restorative Program policy			
		at night when it's dark and no		call light system at the nursing s			
	one comes." R12 st	tated, "Staff can't come right		trainings on 12/1 and 12/2.			
		can't leave the person they're					
		stated, "They always put you y I'll be right back, but they		Audits of customer concerns and response time will be completed			
		R12 stated, "I'll be right back		for 4 weeks.	JA/WEEK		
		ords." R12 stated, "I start out		Audits of completion of restorativ	ve plnas		
	using my walker to kids say don't do th	get to the bathroom, but my at, I might fall."		and accompanying documentati completed 3x/week for 4 weeks.	on will be		
	During an interview	on 10/22/20, at 1:31 p.m.		The facility will conduct resident interviews and care audits, with	an		
		walk me once a week, I'm		emphasis on individualized care			
	doing good, and I d	lo need it. I am getting weaker		preferences 3x/week for 4 week	S.		
		not going to last long at this		Administrator/Designee is respo	nsible for		
		enough." R12 stated she n the hallway. R12 stated that		compliance. Results of monitoring shall be re	norted at		
		would ask staff if she could		the facility Quality Council meeti			
		"Later, but later never comes."		ongoing frequency and duration	to be		
	<b>D</b> 40			determined through analysis and	l review		
	R13 R13's face sheet in	rinted on 10/23/30, indicated		of results.			
		(impaired balance or					
	coordination), dege	neration of nervous system					
	(loss of function or spinal cord).	structure of nerves of the					
		imum Data Set (MDS)					
		9/29/20, indicated R13 was					
		ad adequate hearing and n, was understood and had					

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́сом	E SURVEY PLETED C
		245153	B. WING				23/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	clear comprehension assistance of one si and toileting, locom walking in room or of twice. R13's care plan goa R13 would continue daily living (ADL's) indicated R13 requi- brushing teeth, groot incontinence care a responsible for these nursing assistants a During an interview R13 stated in the lat lost a lot of staff and stated, "I look at thr personality, efficien stated, "Most of the don't treat us with ro personable." R13 stated and today I waited a "They are short stata" "Management push working double shiff seeing good staff le R13 stated, "Person consequences to has be answeredyet."	on. R13 required extensive staff for bed mobility, transfers notion on and off the unit, and corridor occurred only once or al dated 7/13/20, indicated e to participate in activities of while able. R13's care plan ired assistance for bathing, oming, dressing, toileting, and ambulation. Staff se activities were identified as and nurses. o on 10/19/20, at 2:09 p.m. ast 6 months, the facility had d staff morale was low. R13 ree things in order to rate staff: icy and timeliness." R13 e pool staff don't have any, espect and are not tated, "With pool staff, I wait a ted, "I used to wait 10 minutes 40 minutes." R13 stated, ffed." R13 stated, nes them. A lot of staff are fts." R13 stated, "I hate eave and just poor ones stay." nally, I have not suffered any aving to wait for a call light to	F 7	25			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
		245153	B. WING	i			C 23/2020
NAME OF	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	bath, "she can't hel not able to get to m used to have a rest use the bicycle and they are short staffe stated the new mar concerned about th residents. R13 state to be here and they needs." R11 R11's facesheet, pr diagnosis of demer debility, osteoarthri R11's quarterly Min assessment dated moderate cognitive hearing and vision, understood and hav required extensive mobility, transfers a on and off the unit. assistance of one w walking in the corrio staff occurred only R11's care plan goa R11 maintain curren with activities of da plan indicated R11 compression stocki grooming, dressing and ambulation. Sta	p me and apologizes she is ie sooner." R13 stated they corative aid and was able to I walk in the hall, but now that ed, she doesn't walk. R13 hagement was more he bottom line than the ed, "I'm paying a lot of money or aren't always meeting my inted 10/23/20, indicated htia, age related physical tis and muscle weakness. imum Data Set (MDS) 8/11/20, indicated R11 had impairment, had adequate clear speech, was d clear comprehension. R11 assistance of one staff for bed and toileting and locomotion R11 required limited when walking in room, and dor with assistance of one		725			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING	i			23/2020
NAME OF I	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	During an interview R11 stated she war have time." R11 sta stated she could no helped her walk. During a telephone p.m. family membe doing very well. FM (soiled herself) quit FM-E stated, "To ge herthey're unders they don't have time call the facility to as just falls on deaf ea overwhelmed and s what's happening." R14 R14's facesheet pri diagnoses of osteo bones), kyphosis (fo obesity and muscle R14's quarterly Min assessment dated cognitively intact, h impaired vision req speech, was unders comprehension. R1 assistance of one s dressing and toiletin assistance of one v limited assistance of unit.	nted 10/23/20, at 1:52 p.m. nted to walk, "but staff don't ted, "I'm losing strength." R11 ot recall the last time staff interview on 10/22/20, at 2:05 r (FM)-E stated R11 wasn't I-E stated R1 had accidents e a bit, and that upset her. et them to find the time to help taffed like everyone else and e." FM-E stated, "I've had to sk them to help toilet her and it urs." FM-E stated, "They're sympathetic, but I don't know nted 10/23/20, indicated arthritis (wearing down of orward rounding of the back),	F	725			

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		IPLETED
		245153	B. WING			C / <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		23/2020
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 725	R14 would continue daily living (ADL's) indicated R14 requ and taking off comp oral care, dressing, incontinence care a responsible for thes nursing assistants a During an interview R14 stated there "a staff to meet her ca have my light on ar 30 minutes." R14 st when I have to go I myself." R 14 stated my own that I'm not "This hallway does hasn't for most of th gone downhill terrik leaving; they don't I have to do and don R14 stated when lo were brought up at heated and the adn and changed the su about it." R14 state allowed to say muc stated, "They say it but it's far from it." I between the worke show." R14 stated s five star place but r stars. During an interview	e to participate in activities of as able. R14's care plan ired assistance with putting on pression stockings, bathing, grooming, toileting, and ambulation. Staff se activities were identified as and nurses. on 10/19/20, at 1:13 p.m. bsolutely was not" enough re needs. R14 stated, "I can ad I've had to wait as long as tated, "I take prune juice, have to go, so I try and go by d, "I'm having to do things on t supposed to do." R14 stated, n't have enough help and ne year I've been here; it's oly." R14 stated, "Staff is ike the amount of work they 't like mandated overtime." ong call lights and staffing resident council, "It got a bit ninistrator backed away from it ubject, he didn't want to talk d, "It was evident we weren't h as he cut us off." R14 's supposed to be our home, R14 stated, "Feels like a war rs and whoever is running the she heard this used to be a now it was considered only two of on 10/19/20, at 10:29 a.m. NA)-A stated, "There is not	F 72			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`́сом	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	when the new adm work was added wi stated there used to residents, but one to NA-A stated randor assist with baths or this means there ar the floor to assist re- lights. During an interview trained medication is different lately but and that leadership few people have lef positions, adding th more than usual. Th younger and the jol TMA-A stated, "It's assistant, but when they bargained for." lot of open positions right now. TMA-A s two nursing assistant what might not get TMA-A stated, "pro fast when they put" During an interview registered nurse (R there was not enou charge nurse, if the nursing assistants, them. RN-C added get his work done, supervising the wor and acting as a res	inistrator came because more thout enough staff. NA-A o be two bath aids for 60 bath aid was taken away. m aids are now assigned to n evening and weekends and re less nursing assistants on esidents and answer call of on 10/19/20, at 2:21 p.m. aid (TMA)-A stated, "Staffing at nothing anyone can control" of was trying. TMA-A stated a ft and no one was applying for here were a lot of pool staff, MA-A stated new staff were b was not what they expected. easy to become a nursing n they get into it, it's more than " TMA-A stated there were a s and a lot of chaos going on tated they were working short, not get to residents very	F 7	725			

Facility ID: 00419

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF PROVIDER	OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONNA TOWE	RS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
to burner During (RN)-A RN-A s lately." but the that son assista home. I nursing hours, s hours." agency availab nursing their wo During the direc can't fir receive taking r census of agen adequa outcom increas seen ar increas it was li would e to the D human applica DON st manage	stated most tated "it see RN-A stated nursing ass metimes the nt to stay lon RN-A stated assistants is of they wo RN-A stated staff and re le. RN-A stated assistants is ork. an interview totor of nurs of staff to fill d push back new admissi for the staff cy staff, DC tely staffed, es such as e in incontir n increase ir e of associa ke a ticking eventually ha DON, there w resources b nts and our ated they w ers, so the r	-	F 7	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	supervisor role and "Staffing was taking is getting done." DO what they have to o improved." DON sta care residents dese During an interview (NA)-B stated shere wa NA-B stated there wa left" and staff were conditions. NA-B st overtime after eight work extra, althoug stated there were o residents, stating sl that morning. NA-B gone due to lack of call lights, turning, w stated, "I've seen lig stressfulI go hom I couldn't do." During an interview (NA)-C stated staffi stated, "We hire ne they leave." NA-C st schedule, but don't When asked what s pressed for time, N residents." NA-C st walk residents who and stated, "Somet do it all." NA-C sta attention of the DO were working on hit	the DON role. DON stated, g all the focus, so nothing else ON stated, "Staff just get done do that day; nothing is being ated, "They can't provide the	F 7	725			

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED		
		245153	B. WING		10	C / <b>23/2020</b>		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•			
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE		
F 725	position was elimin expected to do it all responsibilities. NA impossible to walk During an interview human resources in hard to fill nursing a substantial monetal positions and for in stated they used to base, but current st family about open p them to come here they got applicants. HR-D stated, "We g assistants who hav care facility in town we are the only pla- a red flag." HR-D st with the local hospi finance manager (F a lot of agency staff FM-C stated staffin huddle daily, they ta hired, who had resi in orientation. FM-C offer reimbursement bonuses. FM-C stated speed up the hiring increase wages. FM homes are in the sa market, too many b the same people." I	ge 63 ated and now all NA's are ong with their other A-C stated, "It's almost residents too, there isn't time." on 10/21/20, at 4:30 p.m. nanager (HR)-D stated it was assistant positions even with ry bonuses for full time ternal referral bonuses. HR-D have an employee referral caff no longer tell friends and positions, "they don't want and work short." HR-D stated , but not qualified applicants. get applications from nursing e worked at every long term in the last three years, and ce they haven't worked. That's tated it was difficult competing tal. During the same interview, FM-C) stated they were using f, but workers do not show up. g was discussed at leadership alk about who was being gned, where new hires were C stated as a corporation, they at tuition, loan forgiveness and ted, "Corporate changed from to a 40 hour work week in ff lost incentive to pick up at they were looking at ways to process and ways to <i>A</i> -C stated, "Other nursing ame boat, it's an overbuilt eds and we are fighting for FM-C stated it was difficult to Best Buy and Hobby Lobby	F 7					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONN	IA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	-	F	725			
	putting individuals t course, paying for t full time position. During an interview corporate vice pres stated, "In this indus challenged, we are to meet the needs of stated there was a and "It's unfortunate	d they were considering hrough a nursing assistant he course and giving them a on 10/22/20, at 11:07 a.m. ident of operations (VPO)-G stry, we are all staffing trying to ensure we have staff of our residents." VPO-G culture issue at this facility e where it's been allowed to					
	resident needs was staffing and how ex stating "leadership providing guidance. that a lot had happe Covid19, changes i and trying to rebuild "We staff some pres	not being able to meet a combination of short isting staff were working, needed to be on the floor and "The administrator stated ened at the facility with n leadership, staff quitting, d. The administrator stated, tty good ratios" and resident e more related to staff					
	Assignments dated Purpose: to ensure accordance with res Policy: Sufficient nu and competency ne services for all resid resident care plans All nursing service p work assignment an accordance with pro practice. Procedure:	staff provide cares in					

ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT CON	. 0938-039 E SURVEY IPLETED
		245153	B. WING			C / <b>23/2020</b>
				STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST		
_		-		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 725 F 755 SS=D	of the residents bas care. 2. Inquires and co should be directed 3. Certified nursin trainees carry out th profession manner established nursing Facility Assessmen 1. Person-centere based upon needs included Quality of assistance, bowel a support, and rehab 2. Staffing is plant based upon census addition, staffing in upon resident need and discharges. Pharmacy Srvcs/Procedures/F CFR(s): 483.45(a)( §483.45 Pharmacy The facility must pro- drugs and biologicat them under an agres §483.70(g). The fa personnel to admin permits, but only ur a licensed nurse.	are determined by the needs sked on each residents plan of oncerns relative to staffing to the administrator/designee. g assistants (CNAs) and heir daily assignment in a and in accordance with g procedures and protocols. t, dated 10/28/19, indicated: ed service and care offered of those we serve. This Care: ADL support, mobility and bladder care and toileting ilitation therapy. hed in advance and altered in all departments. In nursing are altered based and the number of admission Pharmacist/Records b)(1)-(3) Services ovide routine and emergency als to its residents, or obtain eement described in cility may permit unlicensed ister drugs if State law inder the general supervision of	F 7			12/4/20
	pharmaceutical ser that assure the acc	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and				

Facility ID: 00419

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245153	B. WING _			C 2 <b>3/2020</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4001 19TH AVENUE NORTHWEST	E			
MADONI	NA TOWERS OF ROC	HESTER INC	ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 755	biologicals) to meet §483.45(b) Service	ge 66 t the needs of each resident. Consultation. The facility ain the services of a licensed	F 75	55				
	pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and							
	in order and that ar drugs is maintained This REQUIREMEN by: Based on interview facility failed to ens were available for a	rmines that drug records are account of all controlled and periodically reconciled. NT is not met as evidenced and document review the ure resident's medications administration per physician sidents (R1 and R9) reviewed rs.		R1's lactulose order was edit indication for use hepatic failu 10/23/20 and order remains a R9 is no longer in the facility. All residents who reside at Ma Towers have the potential to b	re on ctive. adonna			
	10/23/2020, include failure, alcoholic cir 1, dementia withour constipation. R1's e 8/4/2020, included bowel movements p R1's physician orde	rovided by the facility on ed diagnoses of hepatic rhosis of liver, diabetes type t behavioral disturbance, and elimination care plan dated is taking lactulose; goal of 2-3 per day due to cirrhosis. ers included: 30 ml three times a day for		"Administering Medications" p reviewed and remains current Alixa Pharmacy "Unavailable Medications" policy was revie remains current. All licensed staff and TMAs w educated on Administering Me and Unavailable Medications 12/1 and 12/2.	t. wed and ill be edications			

Facility ID: 00419

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DAT	E SURVEY	
		245153	B. WING _			C 10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE	•	
MADONI	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 755	constipation (start of -Hydrocortisone 5 r tablets three times -Glucosamine-chro day (start date 8/19 R1's medication ad identified multiple d given related to the -8/4/2020, MAR- or drug/item unavailat -8/5/2020, MAR - 3 administered: drug/ -8/6/2020, MAR - 2 administered: drug/ -8/30/2020, MAR - 2 administered: drug/ -8/30/2020, MAR - 2 drug/item unavailat -9/15/2020, MAR - drug/item unavailat -9/27/2020, MAR - drug/item unavailat -9/27/2020, MAR - administered: drug/ Glucosamine -Chro -8/22/2020, MAR - 2 administered: drug/ R9 R9's Face Sheet pr 10/23/2020, include hypertension, veno the liver, Chronic ki	date 8/19/2020). milligrams (mg); administer 1-2 a day (start date 8/19/2020) ndroitin 500-400 mg twice a b/2020). ministration record (MAR) loses of lactulose were not medication not available. ne dose was not administered: of 3 doses were not fitem unavailable. of 3 doses were not fitem unavailable. 2 of 3 doses not administered; ole. 1 of 3 doses not administered; ole. 2 of 3 doses not administered; ole. 1 of 3 doses not administered; ole. 1 of 3 doses was not fitem unavailable ondoitin 2 of 2 doses were not fitem unavailable. provided by the facility on ed diagnoses of essential us insufficiency, cirrhosis of dney disease stage 3, insufficiency, and secondary	F 75	Audits of Electronic Medica Administration system "Add Compliance Report" for me available/no given will be co 3x/week for 4 weeks. Administrator/Designee is a compliance. Results of monitoring shall the facility Quality Council ongoing frequency and dur determined through analys of results.	ministration ed not ompleted responsible for be reported at meeting with ration to be		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245153	B. WING				C 2 <b>3/2020</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	A TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 755	R9's physician orde -Amitriptyline 2%-ke lipoderm cream, ap topically two times a -Nystatin powder 10 application four time 9/21/2020) -Hydrocortisone cre Ketoconazole and a twice a day (start da 10/3/2020) R9's medication ad identified the medic not available to adm Amitriptyline cream Medication adminis 10/5/2020, medicat drug/item unavailab Nystatin MAR 9/21/2020, 2 o administered; pharr drug/item unavailab MAR 9/22/2020, 4 o administered; drug/ MAR 9/23/2020, 1 o administered; drug/ MAR 9/28/2020, 2 o administered; drug/ Hydrocortisone creat MAR 9/21/2020, 2 o administered; drug/ Hydrocortisone creat MAR 9/21/2020, 2 o administered; drug/ MAR 9/21/2020, 2 o administered; drug/ MAR 9/21/2020, 2 o administered; drug/ MAR 9/21/2020, 2 o administered; drug/ MAR 9/21/2020, 2 o	ers included: etamine 5% -lidocaine 2% in ply to bilateral knees 1 gram a day (Start date 9/28/2020). D0,000 unit/gram; one es a day (start date eam 2.5% Mix 1:1 with apply to the effected area ate 9/21/2020, stop date ministration record (MAR) ated cream/ointments were ninister per physician orders. tration record (MAR) on ion was not administered; ole. of 4 application not macy won't send and ole. of 4 applications not item unavailable. of 4 applications not item unavailable. of 4 applications not item unavailable. of 4 applications not item unavailable. of 4 applications not item unavailable.	F 7	755			

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PRINTED: 11/25/2020

	-	AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	СОМ	E SURVEY IPLETED C
		245153	B. WING	i			23/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MADON	NA TOWERS OF ROC				4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	unavailable MAR 9/26/2020, 1 of administered; drug/ MAR 9/27/2020, 1 of administered; drug/ MAR 9/30/2020, 1 of administered; drug/ MAR 10/2/2020, 1 of administered; drug/ During an interview trained medication medication was not to let the nurse kno are supposed to ord unawareness if it w error if the medication pharmacy. During an interview director of nursing ( were not available f considered a medic medication error re- completed, the phy notified, and the phy During an interview Allixa pharmacy teo medications were d was a medication n just give when the r confirmed pharmacy available 24/7, how to communicate the immediately. PT sta have the medication	of 2 applications not /item unavailable. of 2 applications not /item unavailable of 2 applications not /item unavailable. of 2 applications not /item unavailable. of 2 applications not /item unavailable. v on 10/19/2020, at 9:37 a.m. assistant (TMA)-B stated if a t available then then supposed ow; if it's not ordered then we der it. TMA-B indicated an vas considered a medication ion was not available from v on 10/20/2020, at 11:16 a.m. (DON) indicated if medications for administration, it was cation error. The DON stated a port should have been vsician should have been	F	755			

Facility ID: 00419

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		AND HUMAN SERVICES			FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245153	B. WING			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 755	Continued From pa considered medical During an interview licensed practical n medication was not medication error an notified. LPN-A indi contacted. LPN-A s did not have the me the back-up pharma 10/23/2020, at 8:30 (DON) stated if a m for administration th be notified. DON sta pharmacy and a ba should be available are scheduled. During a return pho at 3:30 p.m. with nu indicated an expect facility for administr expected to be noti available. NP-B ind R1's lactulose was was not available. The Accepting Deliv dated 9/2018, inclu-	age 70 tion error. y on 10/22/2020, at 9:34 a.m. hurse (LPN)-A stated if a t available it was considered a and the nurse should be iccated the pharmacy should be stated if the primary pharmacy edication then we would call	F 75	DEFICIENCY)	PRIATE	DATE
	noted the nurse not follow the directions correcting any error completed on the p	tifies the pharmacy. Nurse will s of the pharmacy for rDocumentation will be harmacy order ticket. 6. ations completed if medication				

If continuation sheet Page 71 of 105

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	1	E SURVEY	
RECTION	IDENTIFICATION NUMBER:				PLETED	
	045450				C	
	245153	B. WING			23/2020	
JER OR SUPPLIER				JDE		
WERS OF ROC	HESTER INC		ROCHESTER, MN 55901			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIC DATE	
		F 7	60		12/4/20	
3.45(f)(2) Resid ication errors. REQUIREMEN eed on observate w, the facility fa dents (R1 and F agement were in accordance tice. This practi- lin administratio ication of the pl ediate jeopardy immediate jeop equired emerge blood glucose to monitor and us and was ider inistrator, direc entionist, and c e IJ on 10/21/2 compliance rer erity level of G, ot immediate jeop ddition, the facil opriate indicatio inister per physi- dents (R1) revie- ings include:	Alents are free of any significant NT is not met as evidenced tion, interview and document ailed to ensure 2 of 2 R4) reviewed for diabetic provided adequate diabetic with current standards of ice, including inaccurate on, inadequate monitoring and hysician, resulted in an <i>x</i> situation for R1. Dardy began on 8/5/20, when ent care due to hypoglycemia level) due to a failure of the assess the resident's diabetic ntified on 10/21/20. The tor of nursing, interim infection culinary director were notified 0, at 12:45 p.m. The IJ was 20, at 5:45 p.m., but nained at a lower scope and a pattern with actual harm but opardy.		regularly reviewed by provid diabetic order set with moni added. R4's orders have been revie regularly reviewed by provid diabetic order set with moni added. All residents residing at Mar have the potential to be affe "Change in Condition" polic and remains current. "Administering Medications' reviewed and remains curre "Medication Error/Occurren reviewed and remains curre Licensed nursing staff, as p abatement plan were reedu facility's insulin administration with emphasis on blood sug and meal intake. Meal intake added for diabetic residents orders to monitor for hyper/ and emergency protocols. Licensed nursing staff, as p abatement plan were education signs/symptoms of hypogly as hyperglycemia.	ders and the toring was ewed and are ders and the toring was donna Towers ected. y reviewed " policy ent. ce" policy ent. art of the cated on the on protocol gar monitoring e has been s and nursing hypoglycemia art of the ated on cemia as well		
	DR MEDICARE FICIENCIES RECTION DER OR SUPPLIER WERS OF ROC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS dents are Free (s): 483.45(f)(2) facility must en 3.45(f)(2) Resid ication errors. REQUIREMEN agement were in accordance tice. This pract lin administration ication of the pl ediate jeopardy immediate jeop equired emerge blood glucose to monitor and us and was ider inistrator, direc entionist, and c e IJ on 10/21/2 compliance rer erity level of G, ot immediate jeop ddition, the facili opriate indicati inister per physidents (R1) revie ings include:	RECTION IDENTIFICATION NUMBER: 245153 DER OR SUPPLIER WERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) dents are Free of Significant Med Errors 2(s): 483.45(f)(2) facility must ensure that its- 3.45(f)(2) Residents are free of any significant ication errors. REQUIREMENT is not met as evidenced eed on observation, interview and document ew, the facility failed to ensure 2 of 2 dents (R1 and R4) reviewed for diabetic in accordance with current standards of tice. This practice, including inaccurate lin administration, inadequate monitoring and ication of the physician, resulted in an ediate jeopardy began on 8/5/20, when equired emergent care due to hypoglycemia blood glucose level) due to a failure of the to monitor and assess the resident's diabetic is and was identified on 10/21/20. The inistrator, director of nursing, interim infection entionist, and culinary director were notified e IJ on 10/21/20, at 12:45 p.m. The IJ was bood on 10/22/20, at 5:45 p.m., but compliance remained at a lower scope and prity level of G, a pattern with actual harm but of immediate jeopardy. ddition, the facility failed to ensure opriate indication for Lactulose and failed to inister per physician orders for 1 of 3 dents (R1) reviewed for medication errors.	DR MEDICARE & MEDICAID SERVICES         FICIENCIES RECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDI         245153       B. WING         DER OR SUPPLIER       245153         WERS OF ROCHESTER INC       ID RECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID REFID REFID REFID REFID REFID TAG         ddents are Free of Significant Med Errors ((s): 483.45(f)(2)       F 70         facility must ensure that its- 8.45(f)(2) Residents are free of any significant ication errors. REQUIREMENT is not met as evidenced       F 70         eed on observation, interview and document ew, the facility failed to ensure 2 of 2 dents (R1 and R4) reviewed for diabetic in accordance with current standards of tice. This practice, including inaccurate lin administration, inadequate monitoring and ication of the physician, resulted in an ediate jeopardy began on 8/5/20, when equired emergent care due to hypoglycemia blood glucose level) due to a failure of the to monitor and assess the resident's diabetic is and was identified on 10/21/20. The inistrator, director of nursing, interim infection entionist, and culinary director were notified e IJ on 10/21/20, at 12:45 p.m., but compliance remained at a lower scope and erity level of G, a pattern with actual harm but at immediate jeopardy.         ddition, the facility failed to ensure opriate indication for Lactulose and failed to inister per physician orders for 1 of 3 lents (R1) reviewed for medication errors. ings include:	DR MEDICARE & MEDICAID SERVICES         FICIENCIES         FICIENCIES         FICIENCIES         FICIENCIES         FICIENCIES         CASIMULTIPLE CONSTRUCTION         A BUILDING         245153         B: WING         B: WING         WERS OF ROCHESTER INC         SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT IS INTOR MATION)         Gality must ensure that its-         AS45(f)(2)         facility must ensure that its-         AS45(f)(2)         facility failed to ensure 2 of 2.         ed on observation, interview and document         in accordance with current standards of         time equired emergent care due to hypoglycemia         indecato for an assess the resident'	DR MEDICARE & MEDICAID SERVICES       OMB NO.         PREEDICARE & MEDICAID SERVICES       OMB NO.         PREEDICARE & MEDICAID SERVICES       (X1) PROVIDERSUPPLER         245153       B WING         245153       B WING         STREET ADDRESS, CITY, STATE, ZIP CODE       4001 19TH AVENUE NORTHWEST ROCHESTER, NM 558001         SUMMARY STATEMENT OF DEFICIENCIES       PROVIDERS PLAN OF CORRECTION (S): 483.45(f)(2)         SUMMARY STATEMENT OF DEFICIENCIES       PROVIDERS PLAN OF CORRECTION (S): 483.45(f)(2)         Gents are Free of Significant Med Errors (s): 483.45(f)(2)       F 760         facility must ensure that its- 345(f)(2) Residents are free of any significant ication errors.       F 760         genemet were provided adequate diabetic in accordance with current standards of the. This practice, including inaccurate in administration, inadequate monitoring and ication of the physician, resulted in an equilate jeopardy situation for R1.       F 760         Immediate jeopardy began on 8/5/20, when equired emergent care due to hypoglycemia blood glucose level) due to a failure of the to monitor and assess the resident's diabetic is and was identified on 10/21/20, at 7:45 p.m., but compliance remained at a lower scope and rity level of G, a pattern with actual harm but it immediate jeopardy.       All residents residents resident of hyper/hypoglycemia and meal intake. Meal intake has been added for diabetic residents and nursing orders to monitor for the typer/hypoglycemia and meal intake. Meal intake has been added for diabetic resident an unvering and meal intake. Meal intake has been added	

Facility ID: 00419

STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED		
		245153	B. WING			C 23/2020		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	23/2020		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE		
F 760	of the liver and dem disturbance. R1's admission Min assessment dated a severe cognitive im with eating, and rec 8/24/20, indicated, physical assist and R1's diabetic care p indicated R1 had ty insulin. R1 goals in complications r/t [re glucose will remain parameters". Corre included, administe ordered, monitor blo observe for any sig hypo/hyperglycemia reading). R1's nutri 10/19/20, directed t and indicated R1's and required cuing (10/19/20). During observation was observed to sit wheelchair with tray Oreo cookies taken diabetic and often t and he did not think low. R1 was not ab already received his	ver] failure, alcoholic cirrhosis nentia without behavioral imum Data Set (MDS) 8/7/20, indicated R1 had pairment, was independent quired insulin. MDS dated R1 required one person supervision for eating. olan revised on 8/27/20, pe 1 diabetes that required icluded, "Will have no elated to] diabetes and blood within prescribed sponding interventions red diabetes medications as ood glucose as ordered, and ns/symptoms of a (low/high blood sugar tion care plan revised on o document meal intake %, intake was 0-50% of meals and encouragement on 10/19/20 at 4:30 p.m., R1 alone in his room in his / table in front of him, with a part. R1 stated he was a imes his blood sugar was low, c he could tell when he was le to articulate if he had s insulin before the evening t articulate if he usually	F 76	<ul> <li>the facility's insulin administratic and signs/symptoms of hypo/hyperglycemia at the nursi trainings on 12/1 and 12/2. Licensed nursing staff will be ed the Change in Condition, Admin Medications, which includes ind use and the Medication error/Oc policies at the nursing staff train 12/1 and 12/2.</li> <li>Audits of blood sugar values and administration records will be con 5x/week for 4 weeks.</li> <li>Symptom recognition and insulin administration audits will be con 5x/week doe 4 weeks with EMR function - "Facility Activity Repon "Administration Compliance".</li> <li>Audits of medication orders for i for use will be completed 5x/week weeks.</li> <li>Administrator/Designee is respon compliance.</li> <li>Results of monitoring shall be react the facility Quality Council meet ongoing frequency and duration determined through analysis and of results.</li> </ul>	ng staff ucated on istering cation for currence ings on d insulin mpleted reporting t" and ndication ek for 4 nsible for ported at ng with to be			

Facility ID: 00419

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245153 B. WING 10/23/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST MADONNA TOWERS OF ROCHESTER INC ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 760 Continued From page 73 F 760 R1's current physician orders included: -Fragile diabetic. Monitor blood glucose at 2:00 a.m. Provide snack as needed (start date 9/14/20) -Blood sugar checks four times a day at 6:00 a.m., 11:00 a.m. 4:00 p.m. and 8:00 p.m. (start date 8/4/20, stop date 8/5/20)- then 8/19/20 to current. -Offer assistance with meals (start date 8/23/20, to current) Novolog aspart u-100; administer 12, 6, and 7, hold insulin aspart if not eating (start date 9/2/20) -Novolog aspart sliding correction scale for blood sugars above 200 mg/dl, three times a day at 8:00, 12:00 p.m. and 5:00 p.m. (start date 8/19/20) -Lantus U-100 pen; administer 24 units in the morning and 12 units at bed time (start date 8/19) Facility Standing House Orders for Symptom Management dated 3/20, included orders for diabetic management. -administer short-acting insulin < 15 minutes before a meal due to rapid onset of action. Hypoglycemia: -If patient is symptomatic, conscious and able to swallow: administer 6 oz. (ounces) of fruit juice, regular pop or other high carbohydrate beverage. Repeat BG (blood glucose) after 10 minutes (min); if < 70, repeat intervention, if after 2 attempts to treat and BG is still <70. notify provider. If patient is unresponsive or unable to swallow: administer glucagon 1 mg (milligram) IM (intramuscularly). Repeat BG after 10 minutes; if <70 and patient still unresponsive, unless contrary to advance care plan-call 911 and notify provider immediately. If BG remains <70 but

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	patient is conscious conscious patient. ( recheck BG after 60 occurrence of any h provider the next but R1's hospital After V included "Monitor b bed time and 0200 hypoglycemia.) Blo mg/dl (milligrams pr goal due to advanc A review of R1's blo conjunction with R1 record (MAR), nurs were reviewed from identified blood sug record did not alwa interventions when addition, R1's recor signs/symptoms of record included doc administration" of ir and failed to demor notified per physicia standing orders. Progress notes on 76 mg/dl, the MAR record) indicated "la gave OJ (orange ju Progress note date indicated R1 was a and supper, physic resulted in an order	s, initiate interventions for the Once patient is stable, 0 minutes. Communicate hypoglycemic event to usiness day. Visit Summary dated 8/4/20, blood glucose 5 times daily, [2:00 a.m.] (To monitor for od glucose goal is 120-180 er deciliter) higher glucose ed age." bod sugar record in I's medication administration sing notes and assessments n 8/1 to 10/19/20. R1's record gars below 80 mg/dl. R1's ys include a reassessment of readings were low. In rd lacked monitoring for hypoglycemia. Further, R1's cumentation of "late nsulin and blood sugar checks, nstrate R1's physician was not an orders or per facility 8/5/20, at 5:09 p.m. BS was (medication administration ate administration: low prior,	F 7	<sup>.</sup> 60			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́СОМ	E SURVEY IPLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	of re-evaluation/mo On 8/7/20, at 12:29 Aspart insulin 20 ur p.m. BS was 33, ga quickly increase blo supper. R1's corres 9:04 p.m., included 4:30 p.m. and was glucagon was admi staff assisted him w went up to 62, after before bed BS was provider was notifie R1's telehealth phy indicated physician gave new orders for referenced blood st mg/dl. On 8/8/20, at 4:00 p orange juice. The p was checked 30 mi record, was not cor note. The BG reco and at 9:45 p.m. wa the progress note in completed 30 minu minutes per order, a symptoms of hypog On 8/9/20, R1's BG taken late at 10:12 p.m. BS was 470 m On 8/11/20, BG at	ponitoring per physician orders. P BG was 112 mg/dl, and hits was administered. At 5:35 ave glucagon (injection to bood sugars) per order and sponding progress note at 1 "Resident BS checked at a 33." The note indicated PRN inistered, R1 was lethargic, with dinner, and checked BS r the meal it went up to 72, and a 291. The record indicated the ed. visician visit dated 8/7/20, r reviewed blood sugars and or insulin. The note also ugar goal range of 120-180 p.m. BG was 68 mg/dl. offered brogress note identified the BS inutes later however the BG nsistent with the progress ord read 452 mg/dl at 8:16 p.m. as 430 mg/dl. Furthermore, ndicated the recheck was ites later rather than 15 and did not include signs and glycemia. B record indicated, BG was a.m. and was 289, at 12:28	F7	760			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		245153	B. WING	i			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	administered Aspar blood sugars was d mg/dl, and 70 mg m note at 8:29 p.m. in glucose at 1600 [4: recorded time on B vitals were stable. F positive shakiness, drowsy. Standing o After 15 minutes re was closely monitor again and it was 70 conscious. On call give additional gluc swallow." The note orange juice with su meal. After 30 minu 116 mg/dl. At 8:00 p On 8/12/20, BS at 7 meal intake was rea 8 units of Aspart wa BS was 61 mg/dl. O at 8:06 p.m. include [inconsistent with re Resident semi alert fluid. 2 ensure supp 125. Resident rega note indicated R1 w shift. The note did r rechecked. On 8/13/20, at 3:10 intake was not reco evidence of intervel and symptoms of h	<ul> <li>At 10 units. At 5:35 p.m. R1's documented as 27 mg/dl, 140 mg/dl. Corresponding progress foluded "Resident blood 00 p.m inconsistent with 6G log] was 27 mg/dl other Resident was symptomatic, sweating, confused, and order glucagon 1 mg IM given. Echecked, 140 mg/dl. Resident red, after 30 minutes checked 0 mg/dl resident was doctor updated and order to cagon if resident is unable to indicated R1 was offered upper, and consumed 75% of utes rechecked and BS was p.m. BS was 251 mg/dl.</li> <li>10:53 a.m. was 118 mg/dl, corded at 50%, MAR indicated as administered. At 4:42 p.m. Corresponding progress note ed "BG check at 3:30 ecorded time on BS record]. t and was able to swallow olements given. BS recheck @ ined his consciousness." The was responsive the rest of the not identify when BS was</li> <li>0 p.m. BS was 69 mg/dl., meal orded. R1's record lacked intion and monitoring for signs</li> </ul>	F 7	760			

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	СОМ	E SURVEY IPLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	indicated physician made adjustments sugars in the morni 200-300. R1's MAR indicated scheduled oral hyd administered: "wou On 8/15/20, R1's m dinner intake was n progress note at 1:3 encouragement and was checked at 12: MAR indicated Asp late at 1:48 p.m. Th recheck prior to the 4:54 p.m. BS was 2 37 mg/dl, at 4:57 p. 5:15 p.m. BS was 2 progress note at 6:3 p.m. [time is incons BS record] to check resident was uncor right away and bloc and other vitals wei glucagon IM as sta still unconscious ar mg/dl. Administered mg IM as standing p.m. and paramedia p.m. Prior to arrival starting to make mo	reviewed blood sugars and to insulin based on high blood ing and bedtime reading of d on 8/15/20, the 4:00 a.m. rocortisone was not ild not wake up for meds". heal intake for lunch and not recorded however, 57 p.m. indicated R1 required d "only ate about 50%". BS 02 p.m. and was 269 mg/dl, aart 9 units was administered he record did not identify a BS e administration of insulin. At 20 mg/dl, at 4:55 p.m. BS was .m. BS was 41 mg/dl, and at 20 mg/dl. Corresponding 53 p.m. included "around 4:15 sistent with recorded time on k scheduled blood glucose, nacious and sweating" Check of sugar and it was 20 mg/dl re stable. Administered STAT nding order. After 10 minutes and blood glucose was 37 d another dose of glucagon 1 order. After 5 minutes blood g/dl. Called 911 around 4:35 cs arrived approximately 4:40 of paramedics resident was povements opened his eyes but t transferred to the ER around R1's MAR did not include the	F	760			

CENTEI STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245153	B. WING				C 23/2020	
NAME OF	PROVIDER OR SUPPLIER		l	s	STREET ADDRESS, CITY, STATE, ZIP CODE		23/2020	
	NA TOWERS OF ROC	HESTER INC		4	001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 760	R1's hospital After N 8/15/20, presented "unconscious due to setting of medication found on 8/15 with a received 2 doses of with minimal improve EMS administered 50% glucose) with it to 120. BG on arriva report, patient has h hypoglycemia lately stable and shivering regards to the patien the collateral history doctor] in Endocrine did not eat lunch bu Additionally, he had hydrocortisone. Both have precipitated his summary indicated and his insulin regin better control of hyp R1's telehealth phyr referenced R1's care event on 8/15/20. T sleepy in the mornin hydrocortisone, and also a strong patter meal when his wife his meals when his adjustments were m R1's telehealth visit physician reviewed make any adjustme	/isit Summary (AVS) dated to the emergency room o severe hypoglycemia in the n misadministration. "He was a blood glucose of 20. He glucagon prior to EMS arrival vement (up to 40 then 50). ½ amp of D50 (an ampule of mprovement of blood glucose al to ED was 116. Per EMS nad repeated episodes of . He was hemodynamically g on arrival to the EDIn nt's episode of hypoglycemia, y collected by [name of blogy reveals that the patient the was still given insulin. I skipped his morning h of these incidents could is hypoglycemic episode." The R1's hypoglycemia resolved men was adjusted to help with boglycemia. sician visit note dated 8/20/20, usal factors of hypoglycemic he note indicated R1 was ng, difficult to administer I "while inpatient, there was n of him completing 100% of was present and only 25% of wife was not there." No	F	760				

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245153	B. WING	i			C 23/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	next week when "w Orders to hold insu On 8/26/20, at 7:15 intake record had 2 dinner; 51-75% and R1 was administered identified Aspart 9 u scheduled before d a.m. BS was 54 mg asymptomatic, app pudding, and pean provided. Correspo "Resident's blood s [inconsistent with re mg/dl. He was alert snack provided." Th sugar was not chec 1:50 a.m. when blo On 8/31/20, at 10:5 included "nurse aw administered. Recc of BS after OJ and signs/symptoms of On 9/3/20, at 11:39 indicated insulin wa lacked interventions signs/symptoms of On 9/7/20, at 12:04 recorded BS was 4 intake record did no before bed. Accord administered at 12: a.m. included, "resi	ve have reliable oral intake. lin if not eating." 5 p.m. BS was 195 mg/dl, meal 2 different intake amounts for d 76%-100 and did not identify ed a bedtime snack. MAR units was administered as linner. On 8/27/20, at 1:16 g/dl. MAR indicated R1 was le juice with sugar, vanilla ut butter crackers were onding progress note included sugar at 12:50 a.m. ecorded BS record] was 54 t and talking. HS [bedtime] he note indicated R1's blood cked until one hour later at od sugar was 159 mg/dl. 60 a.m. BS was 70 mg/dl, MAR are, gave OJ"; insulin was not ord lacked evidence of recheck monitoring for hypoglycemia. 9 a.m. BS was 65 mg/dl, MAR as not administered. Record s, recheck, and monitoring for	F	760			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	<ul> <li>83. Gave milk and or recheck BS after. Wisigns of hypoglycer</li> <li>R1's physician teleling referenced low BS 9/6. Note further indice to insuling the made to insuling the note directed for administering insulic continue to monitor</li> <li>NP/PA/MD if BS &lt;8 weekly."</li> <li>On 9/15/20, at 7:02 indicated insulin war administered peant juice with sugar. Princluded, "BG at 06 with 3 sugar packed the note also indicing lunch was 436 mg/d that R1's blood sug was monitored follow</li> <li>R1's record lacked notified of blood sug was monitored follow</li> <li>R1's progress note indicated R1 was for record did not ident taken. At 3:06 a.m. record did not ident progress note at 3: [3:00] was 74. Orar added was given. Fwas 131." The MAF</li> </ul>	chocolate pudding and Vent up to 183. No visible mia." health visit note dated 9/8/20, readings, 64 on 9/3 and 58 on dicated no adjustments would because of highs and lows. or nursing to continue in per orders and, "Nursing to patient closely, notifying 80. Review blood sugars 2 a.m. BS was 60 mg/dl. MAR as held and R1 was ut butter cookies, and orange ogress note at 12:14 p.m. 500 was 60. He was given OJ ts and ate a good breakfast." ated R1's blood sugar prior to dl. The note did not identify par was retaken and that R1 owing the interventions. evidence the physician was	F 7	760			

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STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245153	B. WING				C <b>23/2020</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	and R1 was admini 12:07 p.m. was 52 and at 1:55 p.m. wa 1:56 p.m. indicated inconsistent with ble "resident was semi ensure given prior t Staff was assisting Recheck BG 144 pc On 10/5/20, MAR 4 record did not ident was administered A documented late at what time the insuli p.m. BS was 64 mg held. Correspondin Included "Resident" mg/dl. Asymptomat check BG after 15 r evidence of snack i rechecked. R1's record lacked notified of blood sug On 10/12/20, at 7:2 meal intake record time snack. On 10/ was 68 mg/dl. R1's interventions, and r symptoms of hypog R1's record lacked notified of blood sug	istered Aspart 12 units. BS at mg/dl, at 1:55 p.m. 144 mg/dl, as 66 mg/dl. Progress note at at 11:00 a.m. (time is ood sugar record) was 52, alert with stimuli. OJ and to lunch. BG recheck at 66. with lunch with >50% intake. ost lunch. Resident is alert." 4:00 p.m. was 273, meal intake tify R1's intake for dinner, R1 Aspart 11 units and was t 8:07 p.m., it's not evident in was administered. At 7:36 g/dl and Lantus insulin was g progress note at 8:06 p.m. 's BG at evening was 64 tic. Offered snacks and will minutes. The record lacked intake, or R1's BS was evidence the physician was gar below 80. 23 p.m. BS was 175 mg/dl, did not identify R1 had a bed 13/20, at 2:20 a.m. R1's BS record lacked evidence of monitoring for signs and glycemia. evidence the physician was	F 7	760			

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		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		` ´COM	E SURVEY PLETED C
		245153	B. WING _				23/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	, ,		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE I ROCHESTER, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	indicated R1 ate 1-2 progress notes indi- did not eat well, ins lacked evidence of monitoring for sings R1's record lacked notified of blood sug On 10/16/20, at 10: intake record did no meal. MAR indicate Aspart 6 units. At 4 4:44 p.m. BS as 88 Corresponding prog included "Res BS a snacks and residen went up to 88. BS 1 did receive snack". rechecks according signs/symptoms of R1's record lacked notified of blood sug During an interview the director of nursi did not have individ house glucometer v unawareness of R1 stated an analysis of completed to ascert the hypoglycemic e having discussion v the R1's hypoglycet intake concern. The educated, only staff	25% of food. Corresponding cated R1 ate <50% of dinner, sulin was held. The record rechecks of BS and s/symptoms of hypoglycemia. evidence the physician was gar below 80. 30 a.m. BS was 183, meal of identify R1's intake for noon ed R1 was administered :15 p.m. BS was 67, and at mg/dl, insulin was held. gress note at 10:03 p.m. at 4:00 p.m. was 67. Gave at ate 25% of his meal. BS 180 at HS [bed time], resident Record lacked evidence of g to order and monitoring of hyperglycemia. evidence the physician was	F 76				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			`́СОМ	E SURVEY PLETED C
		245153	B. WING				23/2020
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	1		001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	R1's record and ver between the admini 911 was called. The are supposed to be meals, and up to 30 insulin administratic and insulin set for the should be 15 minutes until saf hypoglycemia/hype notification per order information was sup progress note During an interview registered nurse (R blood sugar at 10:4 mg/dl, she did not a when he got his lun tray would be delive indicated R1's blood even though it was insulin would be ad During an interview licensed practical n sugars are taken wi aspart was suppose meal, and if BS low interventions and re During an observat at 4:05 p.m. RN-E s already been obtair sugar was taken at administered short	on 10/20/20, at 11:39 a.m. N)-A, stated she took R1's 0 a.m., blood sugar would ch tray. RN-A stated his lunch ered around 11:45 a.m. RN-A d sugar would not be retaken obtained over an hour before	F	760			

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ	E SURVEY IPLETED
		245153	B. WING			C <b>23/2020</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	stated R16's blood p.m. was 199, RN-I units was administe tray delivery. During an interview NA-C stated meal i recorded because of with meals and coll would put the tray i eat by himself but of with eating, R1 would stated R1 had low a he was low he acts NA-C stated R1's b before meals howe before meals howe before meals. During an interview NA-F stated meal in documented but did NA's were aware of they had to wait to they had their blood residents got their i low the nurse would resident to eat. During an interview licensed practical m acting insulin shoul minutes before the blood sugar was or meal, then the insu should be evaluate eating.	age 84 sugar was at around 3:30 E administered R16's aspart 6 ared at 4:50 p.m. with meal of on 10/22/20, at 9:23 a.m. ntakes didn't always get different staff are assisting ecting trays. NA-C stated staff n front of R1 to see if he would otherwise required assistance uid take a bite then stop. NA-C and high blood sugars, when a different, he would fall asleep. blood sugar would be taken ever, unaware of how long of on 10/22/20, at 9:56 a.m. ntake was supposed to be dn't always do it. NA-F stated f who were diabetics because give residents trays until after d sugar checked and the insulin. If the blood sugar is d tell us what to give the of 10/22/20, at 9:34 a.m. purse (LPN)-A stated rapid d be administered 15-30 meal. LPN-A indicated if n the lower side before the lin dose and blood sugar d, and held if resident not	F 760	,		

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
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		245153	B. WING				C <b>23/2020</b>
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			1001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	practitioner (NP)-B hypoglycemic even sugars obtained by his A1C. NP-B indic information from the intakes. NP-B state hypoglycemia was meal and that he re that information had nursing staff. NP-B was not checked cl was administered b dependent on how when the resident a hypoglycemia. NP- not be administered meal- if not with the documentation sho the medication was blood sugar checks meal intake are not makes it difficult to doses. NP-B stated are written for each notifying the physic standing orders. NF for hypoglycemia sl done after 15 minut continued monitorir sugars are low. NP- documentation be of and response to the The IJ which began 10/22/20 at 5:45 p.1 acceptable plan of which included: The	verified familiarity with R1 and ts. NP-B indicated R1's blood the facility are not reflective in cated she had difficulty getting e facility, such as meal ad thought that R1's a result of not finishing his equired assistance, however d not been reported by facility indicated if the blood sugar ose to meal times and insulin based off the blood sugar and much time had elapsed and ate, could cause B stated aspart insulin should d before 15 minutes prior to a e meal. NP-B indicated uld be done immediately after a administered. If the timing of s, insulin administration, and completed accurately, it make adjustments to insulin I parameters for notifications resident, staff should be ian per order or per the P-B stated physician's orders hould be followed; rechecks tes until normal, in addition to ng for hypoglycemia when the -B stated an expectation that completed of the interventions	F 7	760			

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	re-evalutaion of R1 conducted by the p with updates to R1' addition all licensed re-educated on the protocol with an em monitoring, and me on signs and sympt Finally, the facility of an auditing system compliance. R4 INSULIN R4's annual Minimu 8/3/20, indicated R4 impairment and wa The MDS also indic R4's care plan date diagnosis of diabete sugars. The interve glucose as ordered importance of not s monitor/document/r hyper/hypoglycemia R4 submitted a grie The grievance inclu coffee area when [r said "I still haven't of insulin was given to states staff told her [Staff name] didn't H get resident breakfa following up include received her menu	's blood sugars was rovider again on 10/22/20, 's plan of care made. In d nursing staff were facility's insulin administration ophasis on blood sugar eal intake as well as education toms of hypo/hyperglycemia. developed and implemented to ensure ongoing um Data Set (MDS) dated 4 did not have cognitive is independent with eating. cated R4 required insulin. ed 8/6/20, identified R4's es and R4 had unstable blood entions included; monitor blood I, instruct resident on skipping meals and snacks, record any signs/symptoms of	F 760			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
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		245153	B. WING	i			C 23/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	- <b>·</b>	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	food." Actions: re-ermed error report. During an interview R4 sat in her room nurses don't admini with meals. R4 state in early September date. R4 stated she breakfast tray after and had to tell staff R4 then stated her couple of hours late night her blood sug she was tired of tell insulin. Medication and Tre 9/9/20, did not idem insulin prior to brea The report identified given at the wrong The report indicated administered until 3 included, "Insulin to prior to food. Nurse R4's physician orde -Novolog Flex Pen Administer 3 units w noon, and 7 units a EATING, or BG <10 the end of each me reduced if she can to ask staff to reduc Novolog based on a should not be allow	A on 10/20/20, at 12:17 a.m. in her wheel chair. R4 stated dister her insulin the right way; ted she had filed a grievance but couldn't remember the e waited over an hour for her she was administered insulin, f she didn't get her breakfast. noon insulin was also a e, and in the middle of the gar was in the 50's. R4 stated ling staff how to administer eatment Incident Report dated htify the administration of akfast as a medication error. d 5 units of aspart insulin was time on 9/9/20 at 3:30 p.m. d the medication was not 3:53 p.m. The report also o be administered with or just e re-educated."	F 7	760			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	9/28/20. -Tresiba FlexTouch administer 21 units 8/5/20, stop date 10 -Insulin aspart; and scale; if blood suga 251 to 350- give 2 u units, if greater than 500, call the physic meals correction as Below 80: subtract 80-100 subtract 1 u give only meal dose R4's blood sugar re- record identified on 7:35 a.m. R4's recor- On 9/9/20, at 12:10 mg/dl. -At 4:41 and at 5:23 mg/dl -At 6:19 p.m. record -At 7:00 p.m. record R4's Medication ad indicated the morni- long-acting insulin u- sugar in adults) 21 3 units was adminis- not had her breakfa- identified the lunch- administered late a- the 5:00 p.m. dose	Pen U-100 (insulin degludec) every morning (start date D/16/20) bunt to administer; per sliding r is 200 to 250- give 1 unit, if units, If 351 to 400-give 3 n 400- give 4 units, and if over ian. Provide correct post is follows three times a day: 2 units from meal dose. unit from meal dose. 101-200 e (start date 3/4/20). ecord was reviewed; the 9/9/20, at 7:32 a.m. and at orded blood sugar was 193. 6 p.m. recorded BS was 270 ded BS was 113 mg/dl ded BS was 227 mg/dl ministration record (MAR) ng of 9/9, R4 Tresiba (is a used to control high blood units at 7:35 a.m. and Aspart stered on time; the MAR did ses were administered late or n., when R4 reported she had ast. R4's MAR on 9/9/20, dose of Aspart 5 units was t 3:43 p.m. The MAR identified of aspart 5 units was t 6:20 p.m. plus aspart 3 units	F	760			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			`́сом	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	A Hypoglycemia Ev 3:37 a.m. indicated was 50, "insulin asp p.m. and 8 units giv units given at 7:35 is confusion/mental la impaired speech, cr included; glucagon juice; the intervention R4's record lacked medication errors a hypoglycemia as a R4's progress note included, "Resident at approx. 0205. Sh closed and wasn't r touched. Skin was mg IM injection retr given in left deltoid. sugar was 69 mg/d arouse. At 0233 sh able to chew a gluc with 2 added sugar sugar was 113 mg/ 197 mg/dL. I was a with her and she st During an interview licensed social wor R4's grievance on 9 yelling out and staff wrong. LSW-A state that R4 had not got administration, the	vent Report dated 9/10/20, at R4's blood sugar at 2:05 a.m. part 5 units given late at 3:35 ven at 6:20 p.m. Tresiba 21 a.m." with symptoms of apse, weakness/fatigue, old and clammy. Interventions injection, glucose tab, fruit	F	760			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	`́СОМ	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	Continued From pa	ıge 90	F 7	760			
	director of nursing ( given insulin after h medication error re nurse was provided nurse who made th her position after sh	y on 10/20/20, at 11:16 a.m. (DON) confirmed R4 had been her meals. DON indicated a port was filled out, and the d education. DON stated the he medication error, resigned he was provided with er insulin administration.					
	RILACIULUSE						
	failure, alcoholic cir	cluded diagnoses of hepatic rhosis of liver, diabetes type t behavioral disturbance, and					
	indicated while R1 Ammonia levels we for concern of hepa improved during the continue lactulose a summary indicated candidate at this tin order "lactulose 10 solution, take 30 ml	nmary (AVS) dated 8/4/20, was hospitalized blood ere 89, "Lactulose was started atic encephalopathy. Cognition e hospital course, so we will at discharge." The discharge R1 was not a transplant ne. The AVS included the gram/15 milliliters (ml) I by mouth three times a day. [bowel movements] per day."					
		re plan dated 8/4/20, included goal of 2-3 bowel movements nosis.					
	. ,	ers included; Lactulose e times a day for constipation					
	R1's medication ad	ministration record identified					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	multiple doses of la to the medication m stools. The MAR wa with R1's bowel mo records identified m were not given relation inappropriately held goal of 2-3 bowel m resident refusals wi and physician notifi 8/4/20, MAR - one of drug/item unavailab 8/5/20, MAR - a of 3 administered: drug/ (no bowel movement 8/6/20, MAR - 2 of 3 administered: drug/ large bm. On 8/7/20, BMR on On 8/8/20, BMR; not 8/9/20, BMR; had to 8/10/20, MAR - 3 of administered relate and "XL [extra large hold". BMR: none 8/11/20, MAR - 1 of administered: Held 8/12/20, BMR; none 8/13/20, MAR - 1 of administered: held 8/13/20, MAR - 1 of administered: on ho medium and large to R1's physician visit "Patient also has hi encephalopathy. He be given 3 times da bowel movements of	ctulose were not given related of available or held for loose as reviewed in conjunction vement record (BMR); the nultiple doses of lactulose ted to medication unavailable, for loose stools, not meeting novements per day and/or thout evidence of re-attempts cation. lose was not administered; ole. 3 doses were not item unavailable. BMR: none nts) 3 doses were not item unavailable. BMR: one e large bm. one wo large bm's 5 3 doses were not d to "one loose bm yesterday" e) bm yesterday", and "on 5 3 doses was not "due to condition". BMR; none e 5 3 doses was not old medium loose bm. BMR; 2 om	F 7	60			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2	
NAME OF	PROVIDER OR SUPPLIER	•	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MADON	NA TOWERS OF ROC	HESTER INC			01 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 760	being administered	age 92 I on a regular basis and is nen the patient has a loose	F 7	60			
	any documentation 8/21/20, MAR - 1 o administered: due bm. 8/22/20, BMR- one 8/23/20, MAR -1 of	18/20, BMR did not identify of 3 doses was not to condition. BMR; one large e large bm f 3 doses was not nold loose bm. BMR; none					
	the recapitulation findirected to continue having 2-3 bowel malso included, "Laco on a couple of occa Writing orders toda	t note dated 8/24/20, included rom the hospital visit that e the lactulose with a goal of novements per day. The note stulose doses have been held asions on review of the MAR. ay to administer to aim to movements per day.					
	due to condition. B 8/27/20, BMR - nor bm. 8/29/20, MAR - 1 o due to condition. B 8/30/20, MAR - 2 o drug/item unavailal 9/13/20, MAR - 1 o On hold for loose s 9/14/20, BMR; one 9/15/20, MAR - 1 o drug item unavailal	ne, 8/28/20, BMR; one small of 3 doses not administered: MR; none of 3 doses not administered; ble. of 3 doses not administered; stools. BMR; one large soft bm. or medium soft formed bm of 3 doses not administered;					

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		AND HUMAN SERVICES			FORM	: 11/25/2020 APPROVED .0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 23/2020	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MADON	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 760	drug item unavailati movement. 10/14/20, MAR- 1 or resident refused. Bl 10 /15/20, MAR- 1 or resident refused. Bl 10/17/20, MAR- 1 or resident refused. Bl R1's record and fact and found medicati for the omitted Lact the physician had b During an interview pharmacy techniciation were delivered to th medication not avait when the medication pharmacy delivery the however facility stat they wanted the me stated if the pharma medication, facility physician; omission considered medication body accumulates a isn't administered a bowel movements i to rise and cause fu mild symptoms wou delirium, and more	ole. BMR; one large bowel of 3 doses not administered; MR; none of 3 doses not administered; MR; one medium soft formed of 3 doses not administered; MR; no documentation. cility information was reviewed on errors were not completed tulose, and lacked evidence been notified. on 10/21/20, at 2:35 p.m. the an (PT) stated medications he facility, if there was a ilable then staff would just give on was available. PT confirmed services were available 24/7, ff would have to communicate edication immediately. PT acy did not have the staff should notify the n of medication was	F 76	60			

Facility ID: 00419

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	-	AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	Continued From pa	ige 94	F 7	60			
	registered nurse (R received lactulose, constipation". RN-0 orders and confirme with the medication hepatic encephalop his job to ensure th medications. RN st held for loose stool based on the wrong During an interview licensed practical n medication was not considered a medic the medication was needed to commun stated medications there was an evalu. During an interview director of nursing ( not available the pr would be a medicat administered when indicated the indicat not have been cons loose stools. During an interview practitioner (NP)-B medication was bei though the issue ha not aware the medi related to availabilit	y on 10/21/20, at 3:02 p.m. RN)-C was asked why R1 RN responded "for C reviewed R1's medication ed the diagnoses associated a was "constipation" and not bathy. RN-C stated it was not e correct indications for ated the medication had been s and shouldn't have been g indication. y on 10/22/20, at 9:34 a.m. hurse (LPN)-A stated if the t administered it was cation error. LPN-A indicated if a not available then the TMA hicate to the nurse. LPN-A could not be held unless ation by licensed nurse. y on 10/25/20, at 8:30 a.m. (DON) stated if a medication is rovider needed to be notified; it tion error if it was not it was supposed to be. DON ation for the lactulose should stipation, and not held for y on 10/29/20, at 3:30 nurse indicated an awareness the ing held for loose stools, and ad been resolved. NP-B was ication was not administered ty. NP-B stated she would otify her for a change if					

Facility ID: 00419

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		AND HUMAN SERVICES			FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING _		C 10/23/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON		HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	Continued From pa needed.	ge 95	F 76	60		
F 761 SS=D	included; To admini safe and accurate r rights of medication Medications are add the orders. Medications are add prescribed time. The person preparin medication will cont questions or concel Obtain vital as order administration prior medications. Sing medication ou at time of medication Any refused medicat documented as a re- re-attempt).If medic Medication Error po Label/Store Drugs a CFR(s): 483.45(g)(I §483.45(g) Labeling Drugs and biologicat labeled in accordant professional princip appropriate accesssi instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acc Federal laws, the fat	ministered in accordance with ministered within their ng or administering the tact the provider if there are rns regarding medication. ered with medication to administering the t in the electronic record/MAR on administration. ation is destroyed and efusal (did not instruct to cation error is noted refer to blicy. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted bles, and include the	F 76	61		12/4/20

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 11/25/2020 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) D	ATE SURVEY
		245153	B. WING	i	1	C D/23/2020
NAME OF F	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MADON		HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	temperature control personnel to have a §483.45(h)(2) The f separately locked, p compartments for s listed in Schedule II Abuse Prevention a other drugs subject facility uses single o systems in which th and a missing dose This REQUIREMEN by: Based on observat review the facility fa not expired and had 1 medication carts. Findings include: During an observati p.m. registered nurs facility had epineph RN-B unlocked the a box that contained 0.3-milligram injecti stated according to expired March 2020 did not have a phar indicated he was no had come from. RN confirmed the media and that the box did stated if we needed emergency kit. Bot	s, and permit only authorized access to the keys. Facility must provide bermanently affixed torage of controlled drugs of the Comprehensive Drug and Control Act of 1976 and to abuse, except when the unit package drug distribution re quantity stored is minimal can be readily detected. NT is not met as evidenced ion, interview, and document iled to ensure medication was a the appropriate label in 1 of the appropriate label in 1 of see (RN)-B stated that the rine in the medication cart. cart and opened the drawer;	F	761	N/A All residents with orders for Epipens hav the potential to be affected. Alixa Pharmacy "Medication Labels" policy reviewed and remains current. All licensed staff and TMAs will be educated on Medication Labels policy at the nursing staff trainings on 12/1 and 12/2. Medication Carts will be audited for expiration dates 1x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported a the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	r

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 10/23/2020	
		245153	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST	_		
MADONI	NA TOWERS OF ROC	HESTER INC		ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 761	Continued From pa	ige 97	F 76	51			
	director of nursing ( should have not be appropriate medica medications that we	on 10/22/2020, at 8:00 a.m. (DON) stated the medication en in the cart without the tion label and stated ere expired should have been cart and returned to pharmacy					
F 806 SS=J	Resident Allergies, CFR(s): 483.60(d)(		F 8(	06		12/4/20	
	§483.60(d) Food and drink Each resident receives and the facility provides-						
		I that accommodates resident ces, and preferences;					
	nutritive value to re food that is initially different meal choic	ealing options of similar sidents who choose not to eat served or who request a ce; NT is not met as evidenced					
	Based on observative review, the facility f were served in a m	tion, interview and document ailed to ensure food items anner to accommodate known esidents (R5) who had a		R5's allergies and care plan ha reviewed and remains current. All residents with food allergies			
	known allergy to pe anaphylactic reaction threatening allergic resulted in an imme	eanuts, and history of on (a severe, potentially life reaction) to peanuts. This ediate jeopardy (IJ) situation		Madonna Towers of Rochester potential to be affected. Meal Tray Identification policy h	have the		
	contained peanuts.			reviewed and remains current. All resident diet tray cards, as p abatement plan have been revi	ewed for		
		)/5/20, when R5, with a known served a dessert containing		resident food allergy information electronic health record data to			

Facility ID: 00419

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) MULTI	(X3) DATE SURVEY COMPLETED		
		245153	A. BUILDIN	G	C 10/23/2020	
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/	23/2020
	NA TOWERS OF ROC	HESTER INC		4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 806	peanut butter. Dieta dessert than what F card which listed ar administrator and d informed of the IJ of facility implemented was removed on 10 non-compliance ren severity of D, isolat potential for more th immediate jeopardy Findings include: R5's Face Sheet in heart disease and d R5's quarterly Minin assessment dated adequate hearing a was able to compre- questions for the br (BIMS) and had no delirium. R5 was in walking, dressing a R5's care plan for r 10/22/18, identified peanuts and cashe During an interview stated he recently r peanut butter and s peanuts. R5 stated recognized the pea stated he had a "lig "two hours went by	ary staff served a different R5 ordered from the dietary a allergy to nuts. The lirector of nursing (DON) were in 10/21/20 at 6:45 p.m. The d corrective action and the IJ 0/22/20 at 6:00 p.m. However, mained at the lower scope and ed, no actual harm, with han minimal harm that is not /. cluded diagnoses of a stroke, dementia. mum Data Set (MDS) 9/17/20, indicated R5 had and speech, understood and ehend. R5 refused to answer rief interview for mental status signs and symptoms of dependent with bed mobility, nd toileting.	F 80	<ul> <li>accuracy.</li> <li>As part of the abatement plan, resdiet cards had a red dot added to attention to a food allergy.</li> <li>As part of the abatement plan, cutstaff were educated on Meal Tray Identification policy and using and following diet cards and again at meetings on 12/1 and 12/2.</li> <li>Culinary staff will have daily pre-reservice huddles at lunch and dimmeals to review resident diet chatwith all culinary staff. A communic book will also identify changes for Food items that contain known refood allergens will be labeled so a staff will be informed to avoid sent these items and alternate options provided.</li> <li>Diet cards and labeled food will b audited 3x/week for 4 weeks for accuracy and food allergens.</li> <li>Administrator/Designee is respon compliance.</li> <li>Results of monitoring shall be repthe facility Quality Council meeting on going frequency and duration t determined through analysis and of results.</li> </ul>	bring linary staff neal er nges ation staff. sident serving ring e iet sible for orted at g with o be	

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 806	R5 stated he didn't added, "it took a go system." Review of R5's prop 6:07 p.m. registered R5 was anxious an bite of a peanut wh reported to RN-B he and when he tasted out. At 7:04 p.m. RI received an order fo given only if R5 was symptoms of shortr gastrointestinal syn closely and did not an allergic reaction epinephrine. A prior incident from documented in the of R5's reaction to r included: "Rt [reside ingested the desset Rt. has a document he had a small bite stomach. Rt. unable allergic reaction but tongue swelled up I remained A x O x 4 and was able to ans rash, difficulty breat swelling noted. VS normal limit) see ch [doctor name] notifi pt. to ER via [ambu	age 99 go to the hospital this time but bod two days to get it out of my gress note dated 10/5/20, at d nurse (RN)-B documented d agitated because he had a ich he was allergic to. R5 e swallowed a small amount d the peanut, he spit most of it N-B contacted a provider and or epinephrine injectable to be s symptomatic. R5 had no ness of breath, rash or nptoms. R5 was monitored develop signs or symptoms of and did not require n 9/28/19 at 6:40 p.m., was record indicating the severity nuts. The documentation ent] reported that he had rt that had peanut butter in it. ted allergy to nuts. Rt. stated . Rt reported an upset e to state symptoms of last t when asked if his mouth or he responded, 'yes'. Rt. (alert and oriented times 4) swer all questions clearly. No thing, itching or mouth 5 WNL (vital signs within hart. On call for [doctor name], ied and gave orders to send lance name] emergently. Pt's ified. Report called to [name	F	306			

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		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	Continued From pa	ige 100	F 8	806			
	cook (C)-C stated a kitchen and then de nursing home, refer kitchen." C-C stated main kitchen with n the server to make C-C stated R5 had for dinner on 10/5/2 bar which contained know how this occu During an interview culinary services di residents were give to fill out for the ney allergies, their men their allergies; CSD his allergy to peanu- incident on 10/5/20 containing peanuts verified "R5 ordered sent the wrong one on 10/17/20, R5 red his menu, but a Mo peanuts was placed discovered in the n not receive the coo CSD-A verified ther culinary staff to kno items to ensure a re for which they were incident report had received food for w stated it would be a worker (SW). Wher	a on 10/21/20, at 9:48 a.m. all food is made in the main elivered to the kitchen at the rred to it as "nursing care d some foods came from the outs in them and it was up to sure R5 did not receive them. requested a butterscotch bar 20, but received a scotch-a-roo d peanut butter. C-C did not urred. o on 10/21/20, at 9:53 a.m. rector (CSD)-A stated en a paper menu at breakfast at day. For residents with food us were customized to include 0-A verified R5's menu listed uts. CSD-A was aware of the , when R5 received a dessert (a scotch-a-roo bar). CSD-A d the proper product, but we s." In addition, CSD-A stated quested an oatmeal cookie on onster cookie containing d on his tray. The error was ursing care kitchen and R5 did kie containing peanuts. re was nothing in place for ow specific ingredients in food esident does not receive food a allergic. When asked if an been completed when R5 hich he was allergic, CSD-A a grievance filed by the social n asked how the SW would ident, CSD-A stated he didn't					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<u> </u>			T	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
						С	
		245153	B. WING			10/:	23/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROCI	HESTER INC			1001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
0(0)15		TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTIC		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE
					DEFICIENCY)		
E 906	Continued From no						
F 806	- 1	genun	F8	306			
	know.						
		on 10/21/20, at 11:03 a.m.					
		eard about R5 receiving the ade with peanut butter at a					
		N-A stated it was up to the					
	person who discove	ered the event to fill out an					
	incident report, add nursing."	ling "in this case, it was					
	nursing.						
		on 10/21/20, at 11:09 a.m.					
		ing (DON) stated she was not a dessert which contained					
		. The DON stated the nurse					
		g RN-B, was an agency nurse					
		rprised I wasn't notified." The ould follow up with RN-B.					
	DON Stated She we	ש-אומרוטווטע עף אומרו זאיי.					
		on 10/21/20, at 6:35 p.m.					
		tated all food was made in the facility and delivered in metal					
		ng care for distribution. LC-B					
	provided a docume	nt displaying the menu for "fall					
		which indicated the quantities nd to nursing care. While the					
		idicate ingredients for any					
	food items, LC-B st	ated nursing care was					
	responsible for dete	ermining resident allergies.					
	On 10/21/20, at 6:4	5 p.m. dietary aide (DA)-A					
		at the steam table, as he					
		onto individual plates and an aide who set the plate on					
	•	old food, beverages and					
	dessert items to each	ch tray. DA-A stated pans of					
		to the nursing care kitchen en in steel containers and put					
		A stated desserts arrived					

Facility ID: 00419

If continuation sheet Page 102 of 105

PRINTED: 11/25/2020

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	`́сом	E SURVEY PLETED C
		245153	B. WING				23/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 806	plated with plastic of cart on wheels. DA- individual resident's order to plate the for cards included nam likes, dislikes and for verified R5's diet can nuts: cashews and DA-A stated he was 10/5/20, when R5 m DA-A was unaware scotch-a-roo bars a looked like buttersor went by the menu t served and on 10/5 they were serving s During an interview 10/21/20, at approx aides (DA)-B, (DA)- did not know there scotch-a-roo bars. I to articulate the diffibetween butterscot bars. The dietary ai with them following further stated there prevent it from occur receive new training among themselves they needed to be m During an interview CSD-A stated after "told staff not to char CSD-A went on to s	over the top, in a tall enclosed -A stated staff looked at the s paper menu and diet card in bod accurately. Resident diet he, room number, allergies, ood preferences. DA-A ard indicated an allergy to peanuts. s working the evening of received the scotch-a-roo bar. the kitchen brought over and stated he thought the bars cotch bars. DA-A stated staff to determine the food being 5/20, there was no indication scotch-a-roo bars. w with dietary staff on kimately 6:55 p.m., dietary -C and (DA)-D, indicated they were nuts or peanut butter in In addition, they were not able ference in appearance tch bars and scotch-a-roo ides verified no one had talked the incident on 10/5/20. They were no changes made to urring again, nor did they g. DA-B stated they talked that night and just decided	F	806			

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES				FORM	: 11/25/2020 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	`́сом	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 806	butterscotch bars, k scotch-a-roo bars. bars were periodica nursing care and w know they containe "they wouldn't." The facility policy t dated 2012 indicate A tray card (or appr for each resident re- culinary services de conforms to physici dislikes and individu- resident are being n The culinary services providing an accura with diet conforming which contains the information, update Name (first ar Room numbe Diet exactly a Beverage pre Food preferer Known food a Special needs substitute) The tray card w corresponding tray The immediate jeop was removed on 10 could be verified th had implemented a residents were not were allergic. Staff	but it was changed to CSD-A verified scotch-a-roo ally served to residents in when asked how staff would ed peanut butter, he verified titled Meal Tray Identification, ed: roved alternative) is provided eceiving meals from the epartment, to ensure that meal ian diet order and that likes, ual special needs of the met. es director is responsible for ate tray card for each resident, g to physician order, and following minimum ed as needed: nd last) er is physician ordered eference inces	F 8	06			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00419

If continuation sheet Page 104 of 105

		AND HUMAN SERVICES				FORM	11/25/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF	PROVIDER OR SUPPLIER	-	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	changes, a red dot bring attention to for cards and food men- ensure adherence preferences. During which contained kn labeled in order for addition, the facility food allergies on di identified in the res record. Staff educa identification policy cards, began on 10 be conducted prior staff worked. A cor been established to changes. Lastly, ar culinary manager of verify they were ac	was added to diet cards to bod allergies. Review of diet nus were followed by staff to to resident food allergies and g meal service, food items nown resident allergens were staff to avoid serving them. In r conducted a verification of et cards against food allergies ident's electronic medical tion on the meal tray , including utilization of diet 0/22/20, continuing for staff to to the next scheduled shift mmunication book for staff had o identify resident diet n audit was conducted by the or designee, of diet cards to curately labeled for diet allergens. Audit results were	F	306			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00419

If continuation sheet Page 105 of 105



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2020

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

## Re: State Nursing Home Licensing Orders Event ID: 243111

Dear Administrator:

The above facility was surveyed on October 19, 2020 through October 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Madonna Towers Of Rochester Inc November 17, 2020 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

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

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

Please feel free to call me with any questions.

M. Pig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00419	B. WING		( 10/2	) 3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	hether a violation has been compliance with all e rule provided at the tag ale number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon				
	result in the assess	iny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a int for non-compliance.				
Minnocoto	abbreviated survey compliance with Sta was found to be NC State Licensure. Pluelectronic plan of co	TS: 20 through 10/25/2020, an was conducted to determine ate Licensure. Your facility DT in compliance with the MN ease indicate in your prrection that you have ers, and identify the date				
LABORATOR'	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE <b>11/24/20</b>

Electronically Signed

STATE FORM

If continuation sheet 1 of 87

	ota Department of He	ealth	1		-	PROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(3) DATE SU COMPLE	
			A. DOILDING		С	
		00419	B. WING		10/23/	2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	_	IORTHWEST		
	1	ROCHES	TER, MN 55	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETE DATE
2 000	Continued From pa	age 1	2 000			
	when they will be c	ompleted.				
	The following comp SUBSTANTIATED: H5153039C, with d H5153040C, with a H5153041C, with d H5153044C, with d	leficiencies cited. deficiency cited leficiencies cited				
	The following comp substantiated H5153042C H5153045C	plaints were NOT				
		led in ePOC and therefore a juired at the bottom of the first				
2 800	MN Rule 4658.051 Staffing requiremer	0 Subp. 1 Nursing Personnel; nts	2 800		1	2/4/20
	home must have of number of qualified registered nurses, nursing assistants residents at all nurs in all buildings if mo	g requirements. A nursing n duty at all times a sufficient I nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on interview facility failed to ens and meet the asses (R11, R12, R13, R	ent is not met as evidenced and document review, the sure sufficient staff to provide ssed needs for 4 of 4 residents 14) who voiced concern with affing in the facility. The lack of		Corrected		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	COM	E SURVEY PLETED
		00419	B. WING			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 2	2 800			
	sufficient staff had residents who resid	the potential to affect all 50 led in the facility.				
	Findings include:					
	R12 R12's facesheet, printed 10/23/20, indicated diagnoses of Parkinson's disease (disease affecting movement), age-related physical debility, osteoporosis (a condition in which bones become weak and brittle), muscle weakness and repeated falls.					
	assessment dated cognitively intact, h impaired vision req speech, was under comprehension. R assistance of two s and toileting, and e	himum Data Set (MDS) 8/18/20, indicated R12 was ad adequate hearing, uiring corrective lenses, clear stood and had clear 12 required extensive taff for bed mobility, transfers extensive assistance of one for her room and locomotion on				
	would reach maxim and improve ability living (ADL's) for ba oral care. The care assistance with eve incontinence care a	al dated 9/3/20, indicated R12 num rehabilitation potential to perform activities of daily athing, grooming, dressing, plan indicated R12 needed ening cares, toileting, and ambulation. Staff se activities were identified as and nurses.				
	R12 stated there w stated staff cannot her call light on and	v on 10/19/20, at 10:58 a.m. as "not enough staff." R12 always come when she puts d stated, "Nothing makes you at night when it's dark and no				

## PRINTED: 11/25/2020 FORM APPROVED

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		00419	B. WING		C 10/23/2020	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	4001 191	H AVENUE NO	ORTHWEST		
	1	ROCHES	STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 3	2 800			
	away because they working with." R12 on the toilet and sa aren't right back." F are their famous wo using my walker to kids say don't do th During an interview R12 stated, "If they doing good, and I d every day and I am rate. I'm not active would like to walk in in the morning, she	tated, "Staff can't come right can't leave the person they're stated, "They always put you y I'll be right back, but they R12 stated, "I'll be right back ords." R12 stated, "I start out get to the bathroom, but my lat, I might fall." on 10/22/20, at 1:31 p.m. walk me once a week, I'm lo need it. I am getting weaker not going to last long at this enough." R12 stated she in the hallway. R12 stated that would ask staff if she could "Later, but later never comes."				
	R13's face sheet, p diagnoses of ataxia coordination), dege	rinted on 10/23/30, indicated a (impaired balance or eneration of nervous system structure of nerves of the				
	assessment dated cognitively intact, h vision, clear speech clear comprehension assistance of one so and toileting, locom	nimum Data Set (MDS) 9/29/20, indicated R13 was ad adequate hearing and n, was understood and had on. R13 required extensive staff for bed mobility, transfers notion on and off the unit, and corridor occurred only once or				
	R13 would continue daily living (ADL's)	al dated 7/13/20, indicated e to participate in activities of while able. R13's care plan ired assistance for bathing,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING			C 23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NOI TER, MN 5590			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	brushing teeth, grou incontinence care a responsible for these nursing assistants a During an interview R13 stated in the la lost a lot of staff and stated, "I look at thr personality, efficien stated, "Most of the don't treat us with re personable." R13 state and today I waited a "They are short state" "Management push working double shift seeing good staff le R13 stated, "Person consequences to habe answeredyet." During an interview R13 stated they use now have only one negatively impacted nursing assistant (N bath, "she can't hel not able to get to m used to have a rest use the bicycle and they are short staffe stated the new mar concerned about th residents. R13 state	oming, dressing, toileting, and ambulation. Staff se activities were identified as and nurses. Toon 10/19/20, at 2:09 p.m. ast 6 months, the facility had d staff morale was low. R13 ree things in order to rate staff cy and timeliness." R13 a pool staff don't have any, espect and are not tated, "With pool staff, I wait a ted, "I used to wait 10 minutes 40 minutes." R13 stated, ffed." R13 stated, use them. A lot of staff are fts." R13 stated, "I hate save and just poor ones stay." nally, I have not suffered any aving to wait for a call light to				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	R11 R11's facesheet, pr diagnosis of demen debility, osteoarthrit R11's quarterly Min assessment dated a moderate cognitive hearing and vision, understood and have required extensive mobility, transfers a on and off the unit. assistance of one w walking in the corrie staff occurred only R11's care plan goa R11 maintain curren with activities of dai plan indicated R11 compression stocki grooming, dressing and ambulation. Sta activities were idem and nurses. During an interview R11 stated she war have time." R11 sta stated she could no helped her walk. During a telephone p.m. family membe doing very well. FM (soiled herself) quit FM-E stated, "To ge	inted 10/23/20, indicated ntia, age related physical tis and muscle weakness. imum Data Set (MDS) 8/11/20, indicated R11 had impairment, had adequate clear speech, was d clear comprehension. R11 assistance of one staff for becomd and toileting and locomotion R11 required limited when walking in room, and dor with assistance of one	5			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00419	B. WING			C 10/23/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	ATE, ZIP CODE			
IADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO STER, MN 5590				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	ige 6	2 800				
	they don't have time." FM-E stated, "I've had to call the facility to ask them to help toilet her and it just falls on deaf ears." FM-E stated, "They're overwhelmed and sympathetic, but I don't know what's happening."						
	R14 R14's facesheet printed 10/23/20, indicated diagnoses of osteoarthritis (wearing down of bones), kyphosis (forward rounding of the back), obesity and muscle weakness.						
	assessment dated cognitively intact, h impaired vision req speech, was under comprehension. R <sup>2</sup> assistance of one s dressing and toileti assistance of one w	nimum Data Set (MDS) 10/6/20, indicated R14 was ad adequate hearing, uiring corrective lenses, clear stood and had clear 14 required extensive staff for bed mobility, transfers, ng. R14 required limited when walking in room, and of one with locomotion on the					
	R14 would continue daily living (ADL's) indicated R14 requ and taking off comp oral care, dressing, incontinence care a	dated 10/15/20, indicated e to participate in activities of as able. R14's care plan ired assistance with putting on pression stockings, bathing, grooming, toileting, and ambulation. Staff se activities were identified as and nurses.					
	R14 stated there "a staff to meet her ca	v on 10/19/20, at 1:13 p.m. absolutely was not" enough are needs. R14 stated, "I can nd I've had to wait as long as					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING			C 23/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ADON	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 7	2 800			
	myself." R 14 state my own that I'm no "This hallway does hasn't for most of ti gone downhill territ leaving; they don't have to do and dor R14 stated when lo were brought up at heated and the adr and changed the s about it." R14 state allowed to say muc stated, "They say it but it's far from it." between the worke show." R14 stated five star place but n stars.	I have to go, so I try and go by d, "I'm having to do things on t supposed to do." R14 stated, n't have enough help and he year I've been here; it's oly." R14 stated, "Staff is like the amount of work they n't like mandated overtime." ong call lights and staffing resident council, "It got a bit ministrator backed away from i ubject, he didn't want to talk ed, "It was evident we weren't ch as he cut us off." R14 t's supposed to be our home, R14 stated, "Feels like a war ers and whoever is running the she heard this used to be a now it was considered only two	t			
	nursing assistant (I enough staff." NA-/ when the new adm work was added wi stated there used t residents, but one NA-A stated randor assist with baths of this means there a the floor to assist re lights.	v on 10/19/20, at 10:29 a.m. NA)-A stated, "There is not A stated staff starting leaving inistrator came because more ithout enough staff. NA-A o be two bath aids for 60 bath aid was taken away. m aids are now assigned to n evening and weekends and re less nursing assistants on esidents and answer call v on 10/19/20, at 2:21 p.m.				
	trained medication is different lately bu	aid (TMA)-A stated, "Staffing ut nothing anyone can control" was trying. TMA-A stated a				

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419	B. WING			C 23/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
MADON	NA TOWERS OF ROO	HESTER INC 4001 19	TH AVENUE NO	DRTHWEST		
		ROCHES	STER, MN 559	01		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	age 8	2 800			
	few people have lepositions, adding the more than usual. The younger and the joe TMA-A stated, "It's assistant, but where they bargained for. Iot of open position right now. TMA-A stated, "profight now. TMA-A stated, "profight now. TMA-A stated, "profight now and acting as istants, them. RN-C added get his work done, supervising the work and acting as a resprovided safe care to burnout and stated." During an interview (RN)-A stated mos RN-A stated "it see lately." RN-A stated mos RN-A stated to stay lo home. RN-A stated hore. RN-A stated to hore. RN-A stated to hore. RN-A stated to hore. RN-A stated	eft and no one was applying for here were a lot of pool staff, "MA-A stated new staff were b was not what they expected easy to become a nursing in they get into it, it's more than " TMA-A stated there were a is and a lot of chaos going on stated they were working short ants this day. When asked done due to working short, obably not get to residents very their call lights on." w on 10/19/20, at 2:57 p.m. RN)-C stated at times that ugh staff. RN-C stated as the e unit was not fully staffed with he chipped in and helped I that made it challenging to such as wound care, rk of the nursing assistants source to them. RN-C felt they , but added short staffing lead	f			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00419	B. WING		10/2	23/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MADONI	NA TOWERS OF ROC	HESTER INC	THAVENUE NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 9	2 800			
	nursing assistants she tried to help them with their work.					
	the director of nursi can't find staff to fill received push back taking new admissi census for the staff of agency staff, DO adequately staffed, outcomes such as f increase in incontin seen an increase in increase of associa it was like a ticking would eventually ha to the DON, there w human resources b applicants and our DON stated they we managers, so the n to resident care and supervisor role and "Staffing was taking is getting done." DO what they have to d improved." DON state care residents dese During an interview (NA)-B stated she u a break as there wa NA-B stated there w left" and staff were conditions. NA-B st	on 10/20/20, at 11:30 a.m. ng (DON) acknowledged they positions. DON stated she at the suggestion of not ons in order to decrease they have. Even with the use N stated they are not yet had not seen negative falls, pressure ulcers or ence. DON added they had a self-transfers, but without an ted falls. DON stated she felt time bomb, stating something appen to a resident. According vere daily meetings with ut stated "We aren't getting current staff is burned out." ere down two nurse urse supervisor got assigned d the DON filled both the the DON role. DON stated, g all the focus, so nothing else DN stated, "Staff just get done lo that day; nothing is being ated, "They can't provide the erve."				

## PRINTED: 11/25/2020 FORM APPROVED

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00419	B. WING	B. WING		C 10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
IADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	residents, stating s that morning. NA-B gone due to lack of call lights, turning, y stated, "I've seen lis stressfulI go hom I couldn't do." During an interview (NA)-C stated staffi stated, "We hire ne they leave." NA-C s schedule, but don't When asked what s pressed for time, N residents." NA-C st walk residents who and stated, "Somet do it all." NA-C sta attention of the DO were working on hi they used to have a position was elimin expected to do it al responsibilities. NA impossible to walk During an interview human resources n hard to fill nursing a substantial moneta positions and for in stated they used to base, but current si family about open p them to come here they got applicants	age 10 he had 15 residents by herself stated things that don't get staff included dirty laundry, walking, and toileting. NA-B ghts be on for an hour. It's the thinking about all the things of on 10/21/20, at 8:42 a.m. ing had been frustrating. NA-C w staff, train them, and then stated, "Agency staff is on the show up at the last minute." she was not able to do when A-C stated, "Checking on my tated she had not been able to or are on restorative programs thing has to give, and we can't ted she had brought this to the N and the DON stated they ring more staff. NA-C stated a restorative aide, but that ated and now all NA's are ong with their other A-C stated, "It's almost residents too, there isn't time." of 10/21/20, at 4:30 p.m. nanager (HR)-D stated it was assistant positions even with ry bonuses for full time ternal referral bonuses. HR-D have an employee referral taff no longer tell friends and positions, "they don't want and work short." HR-D stated , but not qualified applicants. get applications from nursing		DEFICIENC	(Υ)		

	ta Department of He	ealth	1			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00419	B. WING		C 10/23/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S			
		4001 197	H AVENUE NO			
MADONI	NA TOWERS OF ROC	ROCHES	STER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 11	2 800			
	we are the only pla a red flag." HR-D s with the local hospi finance manager (F a lot of agency staf FM-C stated staffin huddle daily, they t hired, who had resi in orientation. FM-C offer reimbursemen bonuses. FM-C state shifts." FM-C stated speed up the hiring increase wages. FI homes are in the sa market, too many b the same people." compete with local wages. FM-C state putting individuals t course, paying for t full time position. During an interview corporate vice presistated, "In this indu challenged, we are to meet the needs of stated there was a and "It's unfortunat go." VPO-G stated resident needs was staffing and how ex- stating "leadership providing guidance	a in the last three years, and ice they haven't worked. That's tated it was difficult competing ital. During the same interview FM-C) stated they were using f, but workers do not show up g was discussed at leadership alk about who was being igned, where new hires were C stated as a corporation, they nt tuition, loan forgiveness and ited, "Corporate changed from to a 40 hour work week in iff lost incentive to pick up d they were looking at ways to g process and ways to M-C stated, "Other nursing ame boat, it's an overbuilt beds and we are fighting for FM-C stated it was difficult to Best Buy and Hobby Lobby d they were considering through a nursing assistant the course and giving them a M on 10/22/20, at 11:07 a.m. sident of operations (VPO)-G ustry, we are all staffing e trying to ensure we have staff of our residents." VPO-G culture issue at this facility we where it's been allowed to not being able to meet is a combination of short kisting staff were working, needed to be on the floor and a." The administrator stated ened at the facility with	я м			

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00419	B. WING	B. WING		C 10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	<ul> <li>and trying to rebuild</li> <li>"We staff some preficare concerns were inefficiencies.</li> <li>Facility policy titled</li> <li>Assignments dated</li> <li>Purpose: to ensure accordance with response: to ensure accordance with response: to ensure accordance with response: for all resider care plans</li> <li>All nursing service portion of the resident care plans</li> <li>All nursing service procedure:</li> <li>Staffing numbe of direct care staff a of the residents base care.</li> <li>Inquires and conshould be directed for the resident care plans</li> <li>Certified nursing</li> <li>Facility Assessment</li> <li>Person-centered based upon needs included Quality of assistance, bowel a support, and rehabition</li> <li>Staffing is plant based upon census</li> </ul>	n leadership, staff quitting, d. The administrator stated, tty good ratios" and resident e more related to staff Staffing and Daily Work 2018, indicated: staff provide cares in sident needs. Imbers of staff with the skills ecessary to provide care and dents in accordance with and the facility assessment. personnel shall follow daily nd perform assigned duties in ofessional standards of rs and the skill requirements are determined by the needs sked on each residents plan of encerns relative to staffing to the administrator/designee. g assistants (CNAs) and heir daily assignment in a and in accordance with procedures and protocols. t, dated 10/28/19, indicated: ed service and care offered of those we serve. This Care: ADL support, mobility and bladder care and toileting	f				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00419	B. WING	B. WING		C 10/23/2020	
ME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
ADONN	A TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 559				
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	age 13	2 800				
	upon resident need and discharges.	l and the number of admissior	1				
	facility administrator revise policies and adequate staff are a timely manner and A designated staff assure cares are b are supported to ad highest practicable psychosocial well-b	THOD OF CORRECTION: The or or DON could review and staffing schedules to assure available to assist residents in d to meet all resident needs. could monitor the system to eing delivered and residents chieve and maintain their physical, mental, and being. R CORRECTION: Twenty-one					
2 830	(21) days. MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and	2 830			12/4/20	
	Subpart 1. Care in receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de and 4658.0405. A be out of bed as m is a written order fr	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the	ł				
	by: Based on interview	ent is not met as evidenced and document review, the nitor and assess for change of		Corrected			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00419	B. WING	B. WING		C 10/23/2020	
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ADONI	NA TOWERS OF ROC	HESTER INC	TH AVENUE NC STER, MN 559				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 14	2 830				
	condition, and faile	d to follow physician orders,					
		R2) who had a history of					
		legs and respiratory concerns					
		pulmonary emboli (PE, clots ir					
		sult of the facility's failures, an					
	immediate jeopardy (IJ) situation was identified						
		played respiratory distress					
		w oxygen (O2) saturations,					
		se in oxygen and emergent					
		bital emergency room (ER).					
		pardy began on 9/25/20, wher end R2 to the ER per orders	1				
	and was identified						
		ctor of nursing (DON), licensed	1				
		/), culinary director, and					
		nist were notified of the					
		y at 12:45 p.m. on 10/21/20.					
	The immediate jeop	pardy was removed on					
		m., but noncompliance					
		ver scope and severity level of	F				
		and severity level, which					
		rm that is not immediate					
	jeopardy.						
	-	lity failed to manage, monitor, of bowel medications to					
		n for 1 of 1 residents (R8),					
		is of constipation and was on					
		life care; and failed to monitor					
		and symptoms of fluid					
		physician orders for 1 of 2					
		a diagnosis of stage 3					
	(moderate) chronic						
	Findings include:						
		nimum Data Set (MDS)					
		9/6/2020, indicated R2 had					
		impairment and required					
		ce from two or more staff for					
	assistance from on	ansfers and required extensive	e				

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00419	B. WING	B. WING		C 10/23/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
MADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 15	2 830				
	required oxygen, w medications, and h	MDS indicated R2 had not as administered anticoagulant ad a surgical wound.					
	embolism, deep vei lower extremity (ad	ncluded diagnoses of acute ing thrombosis (DVT) of right ded 9/14/2020), and					
	R2's Physician star following: Initiate ar	Ilapse) (added 9/1/2020). Inding orders included the Ind titrate supplemental 02 at					
	PRN (as needed) fo breath), hypoxia (02	minute) via nasal cannula or dyspnea (shortness of 2 saturation <90%); and to					
	R2's care plan date experienced hypert	h nursing assessment. d 9/11/2020, indicated R2 ension. Interventions were administer medications as					
	ordered, check bloc observe for signs o	od pressure per order, and f high blood pressure s, chest pain, dyspnea. The					
	care plan did not ac outlined in Required	ddress the instructions as d Follow Up section of the					
	vein thrombosis (A clots form in veins l	Summary to monitor for deep condition in which the blood ocated deep inside the body)					
	which a blood vess by a blood clot).	embolism-A condition in el in the lung(s) gets blocked					
	dated 9/14/2020, ha Issues Requiring Fo	arge Summary Brief Overview ad a section called, Active ollow-up. This section					
	lower extremity for	close monitoring of the right propagation/worsening of of neurovascular compromise					
		numbness/tingling, n in the distal extremity, v evidence of shortness of					
	breath, chest pain,	and/or hypoxemia that may of possibility of pulmonary					

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		C 10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC 4001 19TH	AVENUE NO	RTHWEST		
		ROCHES1	TER, MN 5590	)1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ae 16	2 830			
	stretch wraps daily as tolerated by pati R2's progress note p.m. included, "02 & lit [liter] per minute. continue to monitor skin assessment wa coloration of right lo surgery 5 centimete R2's physician visit recapitulation of ho discharge orders for right lower extremit signs/symptoms of worsening DVT, an note indicated nurs need when working physical therapy re- oxygen for therapy shortness of breath tingling in the extrem physician would con increasing oxygen. bluish coloration of right leg. The note if sounds and "3. Nur monitoring of right I diminished/loss of p new/worsening pair weakness, shortnes and/or hypoxemia t pulmonary embolist R2's progress note p.m. indicated a tele from the NP (nurse be increased to 3 lp "Resident noted to subsequent note at	for swelling control symptoms ent." dated 9/14/2020, at 10:36 34 when lying. O2 started at 1 Call light within reach. Will ." The note also indicated a as completed; purple blueish ower leg, edema +1. Scar from ers long. dated 9/15/2020, included spital admission and r active surveillance of the y, monitoring for pulmonary embolism, d oxygen requirements. The ing reported increased oxygen with physical therapy, and quested order to increase sessions. Resident denied , chest pain, numbness and mity. The note indicate the nsult with vascular clinic for Physical exam, skin: Purple right lower leg. Edema +1 ncluded orders for ultra sing will continue close ower extremity for swelling, pulse, numbness/tingling, n in the distal extremity, ss of breath, chest pain, hat may suggest possibility of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE NO STER, MN 5590			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 17	2 830			
	"PT [physical therap in w/c [wheelchair] refusing it. Pt on ro- to stand CGA [conta for 1 min [minute] w O2 and initially 92% decreased to 73% a rebound. PT donne Stood 2nd time and finger and decrease [seconds] of standin down. Vital machine cord retrieved to plu place O2 at 78% ar >90%. O2 increase time and watched O 20 sec and had pt s recover. Reassesse back to room air an quickly above >90. to room air w/ pt at of pt desaturation w give meds." R2's progress note a.m.stood with PT f let patient stand lor Donned oximeter a entire stand. After s to 81% after sitting therapeutic rest at 15 seconds only as and made pt sit dow with about 1 mine to standing attempts a	100%. Pt stood 2nd time and O2 dripped to 85% quickly wn with O2 dropping to 74% o recover. Discontinued	t			

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00419	B. WING		C 10/23/2020	
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	4001 19T	H AVENUE NO	RTHWEST		
ADON	NA TOWERS OF ROC	ROCHES	TER, MN 5590	01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ae 18	2 830			
	down. A subsequer "PT just completed [treatment]: Pt foun on room air. O2 SA compared to L [left] on 3 lpm to increas increased to 95%. If wheeled walker] an 25 sec of standing at took 2 1/2 min to re going to stand pt ag use toilet urgently at transfer quickly to k rest prior to toilet tra decreased to 49% on otified nsg [nursing toilet and updated at toilet>w/c transfer v changing and clear to 39% with O2 on recover >90%. Nurs withheld. At rest in 60's to 100% while R2's clinic registered note dated 9/18/202 received from nurse Towers, Resident w when resident's 02 Room air sats were resident's 02 sats w oxygen 3L on, ever no apparent distres cyanosis (bluish dis asked for accuracy states they compar were getting the sa states readings were standing and sitting	at note at 1:13 p.m. included, the following concerning tx d asleep in w/c w/ lunch tray, TS 84% on R [right] hand and hand at 80%. PT donned O2 e O2 SATSs for mobility and Pt stood CGA w/ FWW [front d decreased to 69% after just and had pt sit back down. Pt cover >90%. PT was not gain, however, pt requesting to ad instructed pt on need to teep O2 SATS up. PT had pt ansfer CGA and O2 on 3 lpm. PT immediately g]. Nurse arrived while pt on and nurse stayed present for v/ CGA and dependent upon ing. O2 SATS then decreased 3 lpm and took 5 1/2 min to se to update NP and rest of tx w/c observed O2 SATS in mid				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00419	B. WING		10/23/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	at 1:43 p.m. include [name of nurse]. 02 place, at 3L was as certain of the accur Resident was just a and treated for DVT embolism, I gave o [hospital name] ED R2's physician note p.m. included "NP of reported that the ar assessed her and f They stated that sh to the ED. Nursing eye on her over the signs 3 times daily call if 02 drops <90 hospitalization) or if Assess for SOB [sh cough, dizziness/lig pain or swelling wh R2's progress note indicated the physic recommended send room for further evaluated her and of hospitalization at the and agreed to have	2. sician's note dated 9/18/2020, ed "Called facility and talked to 2 sat reading was all over the allow as 50% and they're acy of the equipment. admitted to [name of hospital] T. With concern for pulmonary rder to send her back to ". e dated 9/18/2020, at 2:25 called [nurse name], who mbulance came, EMT found her 02 sat was normal. e's stable and did not take her was instructed to keep a close e weekend. 1. Take VS [vital for 3 days. Notify [provider] on % on 1 LNC (baseline since f RR [respiratory rate] >24. 2. nortness of breath], chest pain, ghtheadedness, increased leg en taking vital signs." dated 9/18/2020, at 3:00 p.m. cian was notified, physician ding R1 to the emergency aluation. Emergency medical and upon arrival; "EMS decided she did not require is time." Physician called back e nursing staff "monitor her ekend. If any changes occur,				
	R2 was seen by the that resulted in "Bill venous thrombosis	documentation of further				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00419	B. WING	B. WING		10/23/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE NO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	R2's physician visit indicated R2 was so The note included a section only include appears well-develor normal mood and a labs on next lab day close monitoring of R2's progress note included "Res [resid command. This AM body was very cold with extra blanket a oxygen was 56 eve Ambulance was cal to the hospital." The the physician had b saturation less than condition. R2's progress note family contacted the close to death. During an interview family member (FM had been at work a nurse at the facility indicated R2 may b room for non-emerg arrived at the facility around 6:00 p.m. th of sending R2 to the had ordered an incu- that on 9/25/2020, of was put up R2's no resulted in not a hu amount, R2 also has stated R2's death of	note dated 9/22/2020, een for initial physician visit. a section Physical Exam; the ed "Constitutional: She oped. Psychiatric: She has ffect." The physician ordered y and for nursing to continue the right lower extremity. dated 9/25/2020, at 9:22 a.m. dent] was not responding to . oxygen was 67 at 4 L. Her to touch. She was covered and was monitored for an hour n with nasal cannula. Iled and she was transferred e note lacked documentation een notified of R2's oxygen a 90% and acute change in dated 9/28/2020, indicated e facility and reported R2 was fon 10/20/2020, at 6:22 p.m. I)-A stated on 9/23/2020, she nd received a call from a before 4:00 p.m.; the nurse e going into the emergency gent cares. FM-A stated she y around 5:20 p.m. and he nurse told her that instead e ER, R2's vascular doctor rease in lovenox. FM-A stated once at the hospital a tube se to pump her stomach that ge amount of fluid but a good id blood in her stools. FM-A ertificate included, ght hip fracture-fall,	,				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
	00419	B. WING			23/2020
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
A TOWERS OF ROC	HESTER INC				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
On 10/21/2020, at 8 (DON) reviewed R2 and stated "the more respiratory status winconsistent docum she was being used to ascertain worser DON stated on 9/28 R2's 02 saturations as well as the phys for an hour. The DO have notified the far when they were go participation in the "progress notes and leave a lot of unans a lack of monitoring changes in color/wa During an interview registered nurse (R low oxygen saturation orders, place on ox physician dependen During an interview RN-B stated he was low oxygen saturation called the physician The Immediate Jeo 10/22/2020, at 5:45 the facility provided competency testing the facility's change emphasis on abnor signs/symptoms of addition, the facility	8:00 a.m. director of nursing 2's oxygen saturation records nitoring and assessing of vas lacking, there was bentation of how much oxygen d therefore would not be able ning respiratory condition." 5/2020, upon discovery of 5, 911 should have been called ician instead of monitoring R2 DN also stated staff should mily member on 9/18/2020, ing to send her in to allow care plan. DON then stated d record are not complete and swered questions. There was g of the lower extremity for armth/sensation or color." o on 10/21/2020, at 3:03 p.m. RN)-C indicated if resident had ions, would check standing tygen and call 911 and/or nt upon situation. o on 10/23/2020, at 5:03 p.m. s the nurse that found R2 with ions. RN-B stated it was an at the time and should have n and ambulance immediately. pardy was removed on 5 p.m. when it was determined a to licensed nursing staff on e of condition policy with mal respiratory status and pulmonary embolism. In developed and implemented		DEFICIENC	21)	
	PROVIDER OR SUPPLIER IA TOWERS OF ROC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa On 10/21/2020, at 3 (DON) reviewed R2 and stated "the mo respiratory status w inconsistent docum she was being user to ascertain worser DON stated on 9/25 R2's 02 saturations as well as the phys for an hour. The DO have notified the fa when they were go participation in the "progress notes an leave a lot of unans a lack of monitoring changes in color/wa During an interview registered nurse (R low oxygen saturat orders, place on ox physician depende During an interview RN-B stated he wa low oxygen saturat error in judgement called the physician The Immediate Jec 10/22/2020, at 5:45 the facility provideo competency testing the facility's change emphasis on abnor signs/symptoms of addition, the facility	OF CORRECTION       IDENTIFICATION NUMBER:         00419       00419         PROVIDER OR SUPPLIER       STREET AI         A TOWERS OF ROCHESTER INC       4001 19T         REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 21       On 10/21/2020, at 8:00 a.m. director of nursing (DON) reviewed R2's oxygen saturation records and stated "the monitoring and assessing of respiratory status was lacking, there was inconsistent documentation of how much oxygen she was being used therefore would not be able to ascertain worsening respiratory condition." DON stated on 9/25/2020, upon discovery of R2's 02 saturations, 911 should have been called as well as the physician instead of monitoring R2 for an hour. The DON also stated staff should have notified the family member on 9/18/2020, when they were going to send her in to allow participation in the care plan. DON then stated "progress notes and record are not complete and leave a lot of unanswered questions. There was a lack of monitoring of the lower extremity for changes in color/warmth/sensation or color." During an interview on 10/21/2020, at 3:03 p.m. registered nurse (RN)-C indicated if resident had low oxygen saturations, would check standing orders, place on oxygen and call 911 and/or physician dependent upon situation. During an interview on 10/23/2020, at 5:03 p.m. RN-B stated he was the nurse that found R2 with low oxygen saturations. RN-B stated it was an error in judgement at the time and should have called the physician and ambulance immediately. The Immediate Jeopardy was removed on 10/22/2020, at 5:45 p.m. when it was determined the facility provided re-education and competency testing to licensed nurs	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00419     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ALTOWERS OF ROCHESTER INC     4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG     D PROVIDER'S PLAN OF (EACH DEFICIENCY WIST (COSS-REFERENCED TO DEFICIENC       Continued From page 21     2 830     2 830       On 10/21/2020, at 8:00 a.m. director of nursing (DON) reviewed R2's oxygen saturation records and stated "the monitoring and assessing of respiratory status was lacking, there was inconsistent documentation of how much oxygen she was being used therefore would not be able to ascertain worsening respiratory condition." DON stated on 9/25/2020, upon discovery of R2's 02 saturations, 911 should have been called as well as the physician instead of monitoring R2 for an hour. The DON also stated staff should have notified the family member on 9/18/2020, when they were going to send her in to allow participation in the care plan. DON then stated "progress notes and record are not complete and leave a lot of unanswered questions. There was a lack of monitoring of the lower extremity for changes in color/warth/sensation or color." During an interview on 10/21/2020, at 5:03 p.m. RN-B stated he was the nurse that found R2 with low oxygen saturations, NN-B stated it was an error in judgement at the time and should have called the physician and ambulance immediately. The Immediate Jopardy was removed on 10/22/2020, at 5:45 p.m. wh	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       00419     B. WING     10////////////////////////////////////

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED		
		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NC TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 22	2 830			
	been admitted to he impairment, and did behaviors. Accordin extensive assistant members for bed m use. The MDS indid incontinent of bower R8's Face Sheet, in bowel syndrome, co R8's care plan date "Resident has a ter receiving hospice s hospice agency], w comfortable as able with hospice for end included, Administer monitor and docum medication. Follow- needed. The elimin 7/28/2020, indicate elimination related opioid medication w s/sx [signs/symptor review date" (goal of interventions includ ordered and observ comfort/pain opioid bowel movement in protocol per standin Observe for s/sx of stools, abdominal b nausea and/or vom (6/29/2020) assist of to/from toilet. R8's physician order- Morphine concentra as needed (PRN) b	7/23/2020, indicated R8 had ospice, did not have cognitive d not have rejection of care og to the MDS, R8 required ce from two or more staff nobility, dressing, and toilet cated R8 was always el. ncluded diagnosis of irritable onstipation, and heart burn. ed 7/17/2020, included minal diagnosis and is ervices through [name of ith the goal of "will be kept as e with through collaboration d of life care." Interventions er medications as ordered, nent effectiveness of -up with hospice/provider as ation care plan edited on d R8 had alteration in to decreased mobility and with the goal of "will have no ns] of constipation through the dated 6/29/2020). The led, administer medications as // for effectiveness, see care plan (7/28/2020), If no n three days follow bowel ng orders (6/29/2020), constipation: passing hard/no ploating/swelling, cramping, iting, mental status changes of one stand pivot wheelchair ers included the following: rate solution 5 milligrams (mg) y mouth every hour as ss of breath or pain (start date				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	7/18/2020, end date -Lactulose (laxative PRN for constipatio date 8/5/2020) -Lactulose 15 ml by take 15 ml daily as date 7/15/2020, end -Lactulose 30 ml tw end date 8/11/2020 -Senna with Docusa two tablets in the m bedtime (start date 7/28/2020), order w take 3 tabs twice a 8/11/2020. -Bisacodyl 10 mg si (start date 7/19/202 -Bisacodyl tablet 5- date 7/15/2020, end -Bisacodyl tablet 5- date 8/5/2020, stop -Fleet enema 19-7 g dose per standing of constipation if no re date 8/2/2020, end Miralax 17 grams o 8/5/2020, end date Facility standing ord constipation; (Perfor rectal check to dete Bisacodyl supposite day for constipation Bisacodyl if no results	<ul> <li>a 8/9/2020)</li> <li>b) 15 milliliters (ml) once a day on (start date 7/15/2020, end</li> <li>c) mouth daily and may also needed for constipation (Start date 8/5/2020)</li> <li>c) rice daily (start date 8/5/2020, )</li> <li>a ate Sodium 8.6/50 mg, take forning and 3 tablets at 7/15/2020, end date 8/10/2020 - day with a stop date</li> <li>c) end date 8/10/2020.</li> <li>10 mg once daily PRN (start date 8/5/2020)</li> <li>mg by mouth once day (start date 8/11/2020)</li> <li>gram/118 ml; 1 tube, one time order (7/26/2020)</li> <li>ube, every three days PRN for esults from suppository (start date 8/11/2020)</li> <li>nce a day (start date</li> </ul>	r			

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		00419	B. WING			C 23/2020
JAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, ST			
		4001 19T				
MADON	NA TOWERS OF ROC	HESTER INC ROCHES	TER, MN 5590	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ige 24	2 830			
	in combination with (BMR), and progress record consistently bowel assessments physical examination distention, presence abdomen. The record medications were mand no follow up of medication was giv R8's progress note R8 reported constig suppository and lax movement. R8's BMR identified movements on 7/23 One PRN dose of L 7/25/2020; dose was effective, no further MAR indicated no F administered. R8's MAR on 7/26/2 administered a Flee special instructions order, with medium p.m. indicated R8 fr and at 7:22 p.m. ha consistency of BM 2 BMR. R8's BMR included - 7/27/2020, medium consistency identifie -7/28/2020, no bow -7/30/2020, no bow	ate of given per physician order effectiveness when the bowel en. dated 7/22/2020, indicated bation "relieved with catives" had large bowel d R8 did not have bowel 3, 7/24, and 7/25/2020. .actulose was administered or as documented as not interventions documented. PRN suppositories were 2020, indicated R8 was ets enema, one time with : Day 4 no BM per standing results. The BMR at 1:22 had a large bowel movement ad a medium bowel movement was not identified on the the following recordings: m bowel movement (no ed). rel movement rel movement rel movement, MAR indicated lose administered was not intervention.	1			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 559	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 25	2 830			
	and was not effectiv -8/1/2020, no bowe - 8/2/2020, R8 had was dry and hard. I administered PRN effective. -8/3/2020, no bowe suppository and lac not effective. -8/4/2020, medium soft/formed. MAR in Bisacodyl administe - 8/6/2020, no bowe Miralax was admini bowel medications -8/7/2020, no bowe scheduled medicat administered and c there was no bowe administered morpl bottom pain 5/10; r effectiveness. -8/8/2020, small bo and hard; MAR idea for day 4 without a documented as effer record lacked evide re-approached. R8 mg at 2:58 p.m. for have bowel movern and at 4:58 p.m. for - 8/9/2020, 2 small (consistency was n R8 refused suppos - 8/10/2020, indicat stool, large loose si movement.	I movement medium bowel movement that MAR indicated R8 was lactulose that was not I movement. PRN Bisacodyl ctulose administered and was bowel movement that was ndicated lactulose and ered and were not effective. I movement; MAR identified stered per schedule, no PRN administered. I movement; MAR identified ions given, Bisacodyl harted as effective although I movement recorded. R8 was hine 5 mg at 4:52 p.m. for ecord lacked evaluation of wel movement that was dry ntified Bisacodyl administered bowel movement; ective. R8 refused Senna S, ence after refusal R8 was was administered Morphine 5 discomfort when trying to hent and shortness of breath, r bottom pain.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 26	2 830			
	Has no bowel move scheduled and as r laxatives and Bisac Fleets enema giver Effective with medi verbalized relief with note also indicated R8's progress note called to update on medication due to o R8's hospice visit n "patient received su digitally remove ha no longer constipat small BM today. Bo quadrants, abdome discussed bowel re reports they will con PRNs as the pt refu laxatives at this tim and recommendation the nurse reported PRN Bisacodyl sup R8's hospice note of indicated family me that pt is in significat and pt is requesting note indicated hosp instructed the nurse Nurse reported that would be administed 12:15 p.m. the fam hospice that a supp with no results, the physician and obta indicated the facility	tote dated 8/3/2020, included uppository and nurse assist to rd stool. Patient reports she is red and staff confirm she had a owel sounds active in to all four en soft and not tender. Writer ogimen with facility nurse, who ntinue to monitor and utilize uses to schedule more e despite writer's education ons." The note also indicated the facility had been giving opositories. dated 8/4/2020, at 9:45 a.m. ember called hospice, "stating ant pain due to constipation, g to go to the hospital." The bice called the facility and e to give prn dose of lactulose. t lactulose and suppository ered later that afternoon. At ily had communicated back to pository and enema were used hospice nurse called hospice ined new orders. The note y would call hospice when R8 edications were given as				

## PRINTED: 11/25/2020 FORM APPROVED

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/23/2020	
		00419	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC 4001 19TI	H AVENUE NO	RTHWEST		
		ROCHES	TER, MN 5590	)1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 27	2 830			
	indicated R8 report bowel medication s per hospice order v "PRN morphine giv transferring, and dia The note indicated visit and via phone management. A sul included, "STAT ve lactulose PRN per placed." Note at 9: had a medium bow Results were comm R8's progress note hospice at the facili Bisacodyl 10 mg da 30 ml twice a day. / p.m. indicated staff bowel movement d According to R8's N administered Morph rectal pain, record of effectiveness of the R8's progress note took her bowel and subsequent note at was applied to resid discomfort after bow R8's progress note indicated hospice v management due to from hospice to sta ordered. The note if the pain medication subsequent note at refused her mornin member was prese	bsequent note at 1:46 p.m. rbal order for another hospice for constipation 54 p.m. included, "Resident el movement this evening." hunicated to hospice nurse. dated 8/5/2020, indicated ty and gave new orders; aily and increase lactulose to A subsequent note at 7:50 had reported R8 had large uring evening cares. MAR on 8/5/2020, R8 was hine 5 mg at 3:23 p.m. for did not identify the e medication. dated 8/8/2020, indicated pain medications. A : 8:47 p.m. indicated cream dents bottom due to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00419	B. WING			C 23/2020
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
			H AVENUE NO	ORTHWEST		
IADONI	NA TOWERS OF ROC	HESTER INC ROCHES	STER, MN 559	01		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 28	2 830			
	"Resident started to	o have peristalsis (the				
		tion and relaxation of the				
		stine or another canal,				
		novements that push the				
		al forward) which caused				
	abdominal discomfort and pain. PRN morphine					
	given hourly per order with less effect on pain					
	management." The note then indicated hospice					
		was contacted and increased morphine.				
	R8's record lacked staffs re-attempt of					
	administration of bowel medications after it was					
	initially refused.					
		dated 8/10/2020, at 5:51 a.m.				
		soft small bowel movement				
	when she was repo					
		dated 8/10/2020, at 1:28 p.m.				
		nted on 8/11/2020 at 1:40				
		sident restless and c/o n." Note indicated R8 was				
		medication and Haldol for				
		r brought Bisacodyl				
		room to administer d/t resident	•			
		medications and only having	L			
	0	nt refusing stating "NO, NO,				
		esidents daughter was in the				
		agreed with residents				
		ere around lunch time and				
		increased anxiety and				
		ote indicated the nurse tried to				
	offer the suppositor	ry again and the resident				
	refused.					
		ote dated 8/11/2020, included				
		k due to complaints of having				
		of nurse] LPN [licensed				
		not give suppository as				
		RN on 8/11/2020 due to pt				
		ot to have hard stool in rectum				
		L [extra large] hard stool. RN plete disimpactaction due to p				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING			C 23/2020
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	have bleeding from (possible hemorrho rectal area to slow pt Dulcolax suppos Bowel sounds hypo disimpacted, she w grimacing or restles note also indicated to hospice house. During an interview nursing assistant (N supposed to record sometimes things of think there was a w NA-D stated the nu sure residents had administer supposit every three days. During an interview NA-C stated NA's v bowel movements l indicated agency st NA-C indicated a su be given if a reside movement every th nurse to administer During an interview licensed practical n were supposed to c and report to the nu movement in 3 day constipation. LPN-A with nurses prior to an assessment to b physician's orders s medications. If a bo	rectum in moderate amounts id). RN applied pressure to down the bleeding. RN gave itory to promote further BM. bactive x 4. After pt was as able to relax with no facial senses noted in bed." The the resident was transferred on 10/21/2020, at 8:51 a.m. NA)-D stated NA's were bowel movements, lidn't get charted, and didn't vay to look back at the history. rses were supposed to make bowel movements and tories if they didn't have one on 10/21/2020, at 9:23 a.m. vere supposed to document however, needed work. NA-C taff were not documenting. uppository was supposed to nt did not have a bowel ree days; that it was up to the the suppository. on 10/21/2020, at 9:34 a.m. urse (LPN)-A stated NA's document bowel movements urse if haven't had a bowel s or if resident complained of A stated TMA's have to check holding any medications for be completed. LPN-A stated should be followed for bowel owel medication was not e follow-up was required. on 10/21/2020, at 12:16 p.m.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00419	B. WING			C 23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 559	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 30	2 830			
	was supposed to be no bowel movement suppository was suppository was suppository was supposed to be completed a complete be completed prior to the medications and/or complain of constip During an interview registered nurse (R assessment should documented prior to laxatives. RN-C ind in three days suppo- if there was not res needed to be comp documentation is n not always identify a standard for size it was left up to the determine difference small/medium/large During an interview director of nursing and confirmed physis management were nursing should hav per physician order documenting refusa administer, if a TM/ should have reported what happened. DO should be completed constipation and/or medication. During a return pho-	apposed to be given. RN ot effective then more losed to be completed. RN bowel assessment should be the administration of bowel when a resident would bation. (on 10/21/2020, at 3:03 p.m. RN)-C stated a complete bowel be completed and o the administration of licated if no bowel movement based to get a suppository, and ults then more intervention bleted. RN-C stated ot always accurate, and does consistency; stated there isn't documentation and indicated person recording to be between				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED C
		00419	B. WING		10/23/2020	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO TER, MN 5590			
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 31	2 830			
	medications per ord enema should not liprescribed medication expectation that nu assessments daily concerns and before medications. R9 FLUID OVERLO R9's admission Mir assessment dated not have cognitive extensive assistant mobility, dressing a MDS also indicated administration of a assessment period R9's Face Sheet, in hypertension, veno the liver (scarring of disease stage 3(mo rheumatic tricuspid heart's tricuspid val secondary pulmona R9's nutrition care identified R9 was of interventions includ fluids, bowel mover applicable each shi low intake and refu R9's Hospital Disch Overview dated 9/2 hospitalized related blood loss. The sec Follow-Up included consider starting To	nimum Data Set (MDS) 9/28/2020, indicated R9 did impairment and required of two or more staff for bed and personal hygiene. The d R9 received one diuretic during the ncluded diagnoses of essential us insufficiency, cirrhosis of of the liver), chronic kidney oderate kidney damage), insufficiency (failure of the live to close properly), and ary hypertension. plan dated 9/23/2020, in a fluid restriction; led document meal intake %, ments, and urinary output as ift. Notify licensed nurse for sed meals. harge Summary Brief 21/2020, indicated R9 was d to anemia iron deficiency ction Active Issues Requiring I primary care provider to orsemide (diuretic) at dose of based on creatinine (lab)				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		00419	B. WING	B. WING		C 10/23/2020	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
		4001 191	TH AVENUE NO	ORTHWEST			
IADONI	NA TOWERS OF ROC	ROCHES	STER, MN 559	01			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE	
				DEFICIENC	(Y)		
2 830	Continued From pa	age 32	2 830				
	-Check heart rate,	blood pressure, and Sp02					
		s) daily (include oxygen					
		ial instructions: Notify [name o	f				
		systolic blood pressure] >160					
	or SBP <90, HR (h	eart rate) >100 or <60, Sp02					
	<90% or increased	l oxygen needs, or with any					
	other concerns (sta	art date 9/24/2020, stop date					
	10/2/2020)						
		blood pressure, and Sp02					
		en requirement) Special					
		[name of hospital staff] if SBP					
		ssure] >160 or SBP <90, HR					
		r <60, Sp02 <90% or					
		needs, or with any other					
		t rate <60 only notify provider ziness/lightheadedness or					
		e 10/2/2020, stop date					
	10/5/2020)	= 10/2/2020, Stop date					
		t. Special instructions <1.5 fluid	4				
	restriction (start da						
		e breakfast. Use the same					
		ler if weight gain >267 lbs.					
		bs. (start date 9/28/2020.					
		grams (mg) now and then					
		g (start date 9/28/2020)					
		wraps to bilateral lower					
		he a.m. and off in the p.m.					
	(start date 9/28/202						
		rd was reviewed; the record					
		es under 60 without evidence					
	the physician had t						
	9/21/2020, 11:49 a						
	9/22/2020, 2:59 p.r						
	9/22/2020, 9:32 a.r						
	9/22/2020, 6:51 p.r						
	9/23/2020, 7:28 p.r 9/24/2020, 10:26 p						
	9/25/2020, 7:34 a.r						
	9/26/2020, 12:25 p						
	$\downarrow$ $\cup_{i} \angle \cup_{i} \angle \cup_{i} \angle \cup_{i} $		1			1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:		`´СОМ	E SURVEY PLETED
		00419	B. WING		C 10/23/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	TH AVENUE NOI STER, MN 5590			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 33	2 830			
	lacked documentat implemented R9's f 9/25/20, 9/30/20, 10 R9's daily weight re- revealed R9 had no days: -9/22/2020, wt. (we -9/23/2020, wt. not -9/24/2020, wt. 256 -weight not taken o 9/29/20. -9/30/2020, wt. 274 -10/1/2020, wt. not -10/2/2020, wt. not -10/2/2020, wt. not -10/3/2020, 276 lbs -10/4/2020, 276 lbs -10/5/2020, wt. not -10/6/2020, wt. not -10/6/2020, wt. not R9's record lacked monitoring and eva edema (swelling ca accumulation in the evidence R9's phys increased weight to R9's progress notes revealed the followi - 9/21/2020, include (pressure applied to of 0-2 millimeters (r immediately) pitting extremities, with wr encouraged to elev -9/22/2020, include time.	ntake from 9/21/20 to 10/5/20, ion the facility had duid restrictions on 9/23/20, 0/3/20 and 10/4/20. ecord from 9/22/20 to 10/6/20 of been weighed 10 of the 15 ight) 264.7 lbs. taken 3.3 lbs. n 9/25, 9/26, 9/27, 9/28, or .2 lbs. taken taken taken taken evidence of consistent luation of R9's weights and used due to excess fluid body tissues) and lacked sician had been notified of the 0.276 until 10/6/20. s from 9/21/20 to 10/6/20 ing: ed resident has grade I o area leaves an indentation				
	-	aluation of hypertension. The				

(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS Continued From pa daily in morning and bilateral lower extre	HESTER INC 4001 19T ROCHES TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DRESS, CITY, ST H AVENUE NO TER, MN 559 ID PREFIX TAG 2 830	DRTHWEST	
(X4) ID PREFIX TAG	A TOWERS OF ROCI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa daily in morning and bilateral lower extre	HESTER INC 4001 19T ROCHES TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 34	H AVENUE NO TER, MN 559 ID PREFIX TAG	ORTHWEST 01 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E COMPLE
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa daily in morning and bilateral lower extre	ROCHES TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 34	ID PREFIX TAG	01 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E COMPLE
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR LS Continued From pa daily in morning and bilateral lower extre	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 34	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLE
TAG	REGULATORY OR LS Continued From pa daily in morning and bilateral lower extre	BC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA	
2 830	daily in morning and bilateral lower extre	•	2 830		
	bilateral lower extre	d apply low stretch wraps to			
	bilateral lower extre				
	at night, ordered lab	bilateral lower extremities, on in the morning off			
	at night, ordered labs for 10/1/2020, and weigh				
		ng state every morning using			
	the same scale.				
		p.m. indicated R9 had low nd heart rate less than 60 and			
		R (a communication tool)			
		t note at 2:29 p.m. indicated			
	R9 had 3+ pitting ed	dema in both legs.			
		p.m. indicated R9 had 3+			
	pitting edema in bot				
		ed R9 was having increased			
		requency and yelling out, ed and faxed for request for			
	urine test.				
	-10/4/2020, indicate	ed R9 continued to yell out			
		confusion, physician was			
		rected to closely monitor and			
		d signs of confusion,			
	test done right now.	ever, and did not want a urine			
	0	ed R9 was calm and slept all			
		ow up with SBAR today.			
		ed "resident had a meeting			
		is morning. Likely in fluid			
		ng diuresis. Provider gave			
		ent to emergency department.			
		s lacked documentation of tatus, edema or daily weights			
	consistently per phy				
		s from 9/28/20 to 10/6/20			
	revealed the followi	•			
		a telehealth visit for			
		tension. The note included			
		order for daily weights with a -267 lb. unfortunately she has			
		ince 9/24/2020 and her			
		was 256.3 lb." The note also			

	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/23/2020	
		00419	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 35	2 830			
	low, usually 90's sy diastolic. The visit i started related to hy labs were ordered, week. -10/1/2020, at 9:00 weight parameters less than 261 lb or [skilled nursing faci has been very inco have been recorder not been weighed a today and up to this documented in EM have made 3 separ for today's weight. I nurse at Madonna included, "Patient of extremity edema, w Her legs are current indicated the plan w hyponatremia, order follow up next week -10/5/2020, "Attem Initially she was wo way to the bathroor again at 11:15 a.m. not log on at 11:15. nursing was ready however, nursing w to call Madonna To nurse. Of note patie tomorrow, can addit time, if nursing sign	pted to see the patient today. orking with therapy and on her m. Nursing agreed to meet me to see patient. Nursing did Received page later stating for me to see patient, vas not signed on. Attempted wers, but could not reach a ent is scheduled for follow-up ress UTI symptoms at that as onto virtual visit. "				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00419	B. WING	B. WING		C 10/23/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	A TOWERS OF ROC	HESTER INC	TH AVENUE NC STER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE	(X5) COMPLE DATE	
				DEFICIENC	CY)		
2 830	Continued From pa	age 36	2 830				
	today. At time of vis	sit she appeared lethargic and					
	unable to answer questions other than to voice her need to urinate." The note also included,						
		name of nurse] patient is					
		oday, [name] states that patien	t				
	has been confused	for two days and has been					
		ry frequency. [Name] also					
		lids appear to be swollen." The	e				
		was alert to person and year					
		here she was located. The					
		physician gave an order to					
	-	ncy room for decline in					
	condition.	10/01/0000 + 0.00					
		<i>w</i> on 10/21/2020, at 9:23 a.m.					
		ried to get daily weights					
		lways happen because staff					
		orning. Stated if we miss a the aide would attempt to get					
	the weight on the re						
		/ on 10/21/2020, at 9:34 a.m.					
		urse (LPN)-A stated edema					
		ed daily with weight. LPN-A					
		think it was being documented					
		portant to identify a change in	,				
	condition.						
	During an interview	/ on 10/23/2020, at 7:42 a.m.					
		(DON) reviewed R9's record					
		ghts were not obtained per					
		na monitoring and evaluation,					
	and the physician v	was not notified when heart					
		per the order. DON stated the					
		identify if R9's was assessed					
	for symptoms for lo						
		one interview on 10/29/2020,					
		urse practitioner (NP)-B, NP-B					
		daily weights at the facility has					
		roblem. NP-B stated residents	<b>;</b>				
		ameters on when to notify the were also given specific					
						1	

TATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00419	B. WING		C 10/23/2020	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
IADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NC TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	directions on obtair morning, before bre NP-B indicated that get the appropriate monitoring and ass fluid balance, and s A facility policy/prot was requested and Facility policy Char included "When a s resident's physical, status is identified B there is need to alte licensed nursing as attending provider a resident/resident re not specifically defii in condition. A facility policy/prot was requested and Facility policy/prot	hing daily weights in the eakfast, using the same scale. t in order for the resident to treatments nursing had to be essing for changes in weight, welling. ocol for fluid management not received. age in Condition dated 2/2019, ignificant change in the mental, or psychosocial by the licensed nurse, or when er treatment significantly, the sociate consults with the and notify the presentative. The policy did ne what constitutes a change ocol for bowel management	2 830			
	rights of medication are administered in 3. Medications are prescribed time. An destroyed and door instruct to re-attem Facility policy Char included "When a s resident's physical, status is identified b there is need to alte licensed nursing as attending provider a resident/resident resident resident	ge in Condition dated 2/2019, ignificant change in the mental, or psychosocial by the licensed nurse, or when er treatment significantly, the sociate consults with the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00419		·	C 10/23/2020	
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADONN	NA TOWERS OF ROC	HESTER INC	TH AVENUE N STER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 38	2 830			
	DON could do qual focusing on resider respiratory condition diagnosis in order to concerns. The DOI conditions that require The DON could the training/competence The DON could de auditing system as assurance program compliance.	THOD OF CORRECTION: The lity of care chart audits nts with acute conditions, ons, constipation, and cardiac to identify any potentia N could review protocals for uire monitoring/assessment. en develop and implement of cy programs to nursing staff. velop and implement an part of the facility's quality in to monitor for ongoing R CORRECTION: Twenty-one				
2 885	Nursing Care; Prog Subpart 1. Program must have an activ nursing care direct resident to achieve practicable physica well-being accordir resident assessme in parts 4658.0400 efforts must be ma and purposeful action	m required. A nursing home e program of rehabilitation ed toward assisting each and maintain the highest al, mental, and psychosocial ng to the comprehensive nt and plan of care described and 4658.0405. Continuous de to encourage ambulation	2 885			12/4/20
	by: Based on interview facility failed to ens services to meet th	v and document review, the sure staff provided restorative le assessed needs for 3 of 3 2, R13) reviewed for		Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00419	B. WING		10/:	23/2020
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
	A TOWERS OF ROC	HESTER INC	FH AVENUE NORT STER, MN 55901	HWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 885	Continued From pa	ige 39	2 885			
	Findings include:					
	diagnoses of ataxia coordination) and d system (loss of func- the spinal cord). R13's quarterly Min assessment dated cognitively intact, h vision, clear speech clear comprehension assistance of one s toileting, and locom	printed on 10/23/30, indicated a (impaired balance or legeneration of nervous ction or structure of nerves of himum Data Set (MDS) 9/29/20, indicated R13 was ad adequate hearing and h, was understood and had on. R13 required extensive staff for bed mobility, transfers, notion on and off the unit. n or corridor occurred only				
	nursing dated 3/25/ restorative program (disease of nerves) the nervous system Goals and approac continue to ambula NuStep (stationary between 6:00 a.m.					
	frequency of restora walking. The report zero times between times, the report lis Other reasons inclu	history report indicated the ative nursing related to indicated R13 ambulated in 9/21/20 and 10/22/20. Three ted the reason as "refused." uded: not observed, could not ue to condition, unavailable				
	During an interview	/ on 10/22/20, at 12:45 p.m.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	or contraction	BENNI IO/TION NONBER.	A. BUILDING: _				
		00419	B. WING			C 10/23/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
	NA TOWERS OF ROC	HESTER INC	H AVENUE NO	-			
	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 885	Continued From pa	ge 40	2 885				
	was able to use the but now that they we happening. R13 stather if she wanted to R13 admitted she sto to the small stature feel safe with them. confident in the abil restorative services of money to be here meeting my needs. brought up at reside management is mo bottom line then the was not able to tell services had affected that it may eventua R12 R12's facesheet, pr diagnoses of Parkir affecting movement debility, osteoporos brittle), muscle weat R12's quarterly Min assessment dated a cognitively intact, he impaired vision requision R1 assistance of two stand to illeting, and references.	inted 10/23/20, indicated nson's disease (disease t), age-related physical is (bones become weak and ikness and repeated falls. imum Data Set (MDS) 8/18/20, indicated R12 was ad adequate hearing, uiring corrective lenses, clear stood and had clear 2 required extensive taff for bed mobility, transfers equired extensive assistance walking in her room and	•				
		egory called restorative /20, indicated R12 required					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		00419	B. WING			C 10/23/2020	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
IADONI	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 885	Continued From pa	ige 41	2 885				
	restorative program to address Parkinson's disease with muscle weakness. Goals and approaches indicated R12 would maintain the ability to ambulate 200 feet daily and ride NuStep for 10 minutes daily, between 6:00 a.m. and 2:15 p.m.						
	frequency of restora walking. The report feet daily during the seven times betwee only one time did sl report listed the rea reasons included: r	history report indicated the ative nursing related to a indicated R12 walked 200 e specified time frame only en 9/21/20 and 10/22/20, and he walk 200 feet. Twice the ason as "refused." Other not observed, could not ue to condition, unavailable					
	R12 stated, "If they doing good, and I d every day and I'm r rate. I'm not active not using the NuSte "They didn't renew no one to sit with yo she would like to we that in the morning,	y on 10/22/20, at 1:31 p.m. walk me once a week, I'm lo need it. I'm getting weaker not going to last long at this enough." R12 stated she was ep at all anymore. R12 stated, that gal's contract so there is ou while you do it." R12 stated alk in the hallway. R12 stated , she would ask staff if she ff say, "Later, but later never	1				
	diagnosis of demer	inted 10/23/20, indicated ntia, age related physical tis (wearing down of bones) ess.					
		imum Data Set (MDS) 8/11/20 indicated R11 had					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00419	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 10/23/2020		
	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE				
		4001 191	H AVENUE NO				
ADONI	NA TOWERS OF ROC	ROCHES	TER, MN 5590	01			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 885	Continued From pa	ige 42	2 885				
	hearing and vision, understood and have required extensive mobility, transfers, and off the unit. R1 of one when walking	impairment, had adequate clear speech, was d clear comprehension. R11 assistance of one staff for bed toileting and locomotion on 1 required limited assistance g in her room, and walked in sistance of staff only once or					
	R11 stated she war have time." R11 sta	on 10/22/20, at 1:52 p.m., nted to walk, "but staff don't nted, "I'm losing strength." R11 ot recall the last time staff					
	nursing dated 3/25/ restorative program (weakness, numbn damage), osteoarth fibromyalgia (wide decreased mobility indicated R11 woul	egory called restorative (20, indicated R11 required to address neuromyopthay ess and pain from nerve mitis of both knees, and spread muscle pain) with Goals and approaches d continue to ambulate 400 he NuStep 10 minutes daily and 2:15 p.m.					
	frequency of restor walking. The report zero times between reasons included: r	history report indicated the ative nursing related to indicated R11 ambulated in 9/21/20 and 10/22/20. The not observed, could not ue to condition, unavailable					
	p.m. family membe doing very well. FN	interview on 10/22/20, at 2:05 r (FM)-E stated R11 was not I-E stated, "To get them to find they're understaffed like					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
00419			B. WING			C 10/23/2020	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
IADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 885	everyone else and could not confirm if doubt it, but I just d "They're overwheln don't know what's h During an interview nursing assistant (N worked without taki much work to get d only two aids to car had 15 residents by stated things that d staff included: dirty walking, toileting. "I It's stressfulI go h things I couldn't do able to provide rest who require it, such know it's not getting staff or the time to b restorative services stated, "They'll dec them." During an interview NA-C stated she ha residents who are of stated "something I NA-C acknowledge were important for balance and streng brought this to the a DON stated they w staff. NA-C stated t aide, but that positi nursing assistants a	they don't have time." "FM-E R11 walked daily stating, "I on't know." FM-E stated, ned and sympathetic, but I	F				

	ta Department of He		1			-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00419	B. WING		C 10/2	; 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	-	
MADONN	A TOWERS OF ROC	HESTER INC				
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 885	Continued From pa	age 44	2 885			
		s did not require special iis was something taught in NA	<b>x</b>			
	DON stated she has assistants to comp it in the electronic r moving onto the new was important so th care history report some nursing assist documenting these medical record). Do challenges of the far recognized that can restorative serves of stated she did not h EMR's to determine being done accord stated when she as restorative serves of nursing assistants said they didn't hav they forgot to docu expectation staff pr	v on 10/21/20, at 11:09 a.m. ad been instructing nursing lete a task and then document medical record (EMR) before ext task. DON explained this nat these tasks show up in the as being done. DON stated stants have been resistant to a tasks in the EMR (electronic ON acknowledged the staffing acility and stated she re plan interventions, such as were not being done. DON have time to look at resident e if restorative services were ing to the care plans. DON sked staff about whether were being done, some said they were doing it, some ve time to do it, and some said ment it. DON stated it was the rovided services as indicated acknowledged there wasn't it.				
	corporate vice pres stated, "In this indu challenged, we are to meet the needs stated there was a and stated, "It's un allowed to go." VPC meet resident need	v on 10/22/20, at 11:07 a.m. sident of operations (VPO)-G istry, we are all staffing trying to ensure we have staff of our residents." VPO-G culture issue at this facility fortunate where it's been O-G stated not being able to ds, was a combination of short kisting staff was working,				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00419	B. WING			C 23/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		4001 19T	H AVENUE NO	RTHWEST		
	NA TOWERS OF ROC	ROCHES	TER, MN 5590	01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 885	Continued From pa	ge 45	2 885			
	providing guidance reported they did no who are on a restor are too busy, VPO- of some issues unti Administrator addee the facility with Cov staff quitting, and tr staff some pretty go concerns were mor Facility policy titled 2017, indicated: Purpose: To ensure comprehensively as restorative needs. 1. Restorative prog each resident can a physical, mental an Restorative nursing highest level of inde including daily living and bed mobility. 2. A registered nurs program to ensure are being implement SUGGESTED MET director of nursing ( review ambulation p conjunction with po director of nursing st of the care plan to i	ssessed / reassessed for rams were established so that attain and maintain highest d psychosocial well-being. care promotes resident's ependence in activities g, range of motion, ambulation se will provide oversight to the the restorative interventions				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
	00419 B. WING			C 23/2020		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 885	Continued From pa	ge 46	2 885			
	(21) days.					
2 945	MN Rule 4658.053 Eating - Nursing Pe	0 Subp. 1 Assistance with ersonnel	2 945			12/4/20
	personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a enhances each res Adaptive self-help of contribute to the res eating. Food and fl be observed and do reported to the nurs resident's care duri observation of a de	g personnel. Nursing termine that residents are scribed. Residents needing be promptly assisted upon s and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in luid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent ns must be reported to the n.				
	by: Based on observati review, the facility f were served in a m allergen for 1 of 1 m known allergy to pe anaphylactic reaction threatening allergic resulted in an imme	ent is not met as evidenced ion, interview and document ailed to ensure food items anner to accommodate known esidents (R5) who had a eanuts, and history of on (a severe, potentially life reaction) to peanuts. This ediate jeopardy (IJ) situation s served food items which		Corrected		

STATEMEN	ta Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00419		B. WING		C 23/2020
	PROVIDER OR SUPPLIER	4001 191 4001 401	DDRESS, CITY, ST	TATE, ZIP CODE DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 945	The IJ began on 10 allergy to nuts was peanut butter. Diet dessert than what card which listed a administrator and o informed of the IJ of facility implemente was removed on 1 non-compliance re severity of D, isola potential for more f immediate jeopard Findings include: R5's Face Sheet ir heart disease and R5's quarterly Mini assessment dated adequate hearing a was able to compr questions for the b (BIMS) and had no delirium. R5 was ir walking, dressing a R5's care plan for 10/22/18, identified peanuts and cashe During an interview stated he recently peanut butter and peanuts. R5 stated recognized the pea stated he had a "lig	D/5/20, when R5, with a known served a dessert containing ary staff served a different R5 ordered from the dietary n allergy to nuts. The director of nursing (DON) were on 10/21/20 at 6:45 p.m. The d corrective action and the IJ 0/22/20 at 6:00 p.m. However, mained at the lower scope and ted, no actual harm, with than minimal harm that is not y. ncluded diagnoses of a stroke, dementia. mum Data Set (MDS) 9/17/20, indicated R5 had and speech, understood and ehend. R5 refused to answer rief interview for mental status o signs and symptoms of independent with bed mobility, and toileting. nutritional status dated a n allergy to nuts, specifically	d.			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00419	B. WING			23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		4001 19T	H AVENUE NO	DRTHWEST		
MADONI	NA TOWERS OF ROC	ROCHES	TER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 945	Continued From pa	age 48	2 945			
	R5 stated he didn't	d damn right I was scared." go to the hospital this time but ood two days to get it out of my				
	6:07 p.m. registere R5 was anxious an bite of a peanut wh reported to RN-B h and when he taster out. At 7:04 p.m. R received an order f given only if R5 wa symptoms of shortr gastrointestinal syr closely and did not an allergic reaction epinephrine.	gress note dated 10/5/20, at d nurse (RN)-B documented d agitated because he had a iich he was allergic to. R5 e swallowed a small amount d the peanut, he spit most of it N-B contacted a provider and for epinephrine injectable to be s symptomatic. R5 had no ness of breath, rash or nptoms. R5 was monitored develop signs or symptoms of and did not require				
	documented in the of R5's reaction to included: "Rt [resid ingested the desse Rt. has a documen he had a small bite stomach. Rt. unabl allergic reaction bu tongue swelled up remained A x O x 4 and was able to an rash, difficulty brea swelling noted. VS normal limit) see ch [doctor name] notifi pt. to ER via [ambu	m 9/28/19 at 6:40 p.m., was record indicating the severity nuts. The documentation ent] reported that he had rt that had peanut butter in it. ted allergy to nuts. Rt. stated rt that had peanut butter in it. ted allergy to nuts. Rt. stated rt then asked if his mouth or he responded, 'yes'. Rt. (alert and oriented times 4) swer all questions clearly. No thing, itching or mouth wNL (vital signs within hart. On call for [doctor name], ied and gave orders to send alance name] emergently. Pt's tified. Report called to [name				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	`´СОМ	E SURVEY PLETED C
		00419 B. WING 1				
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
ADON	NA TOWERS OF ROC	HESTER INC	H AVENUE NOI TER, MN 5590			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE <sup>-</sup> DATE
2 945	Continued From pa	ge 49	2 945			
	cook (C)-C stated a kitchen and then de nursing home, refer kitchen." C-C stated main kitchen with n the server to make C-C stated R5 had for dinner on 10/5/2 bar which contained know how this occu During an interview culinary services di residents were give to fill out for the ney allergies, their men their allergies; CSD his allergy to peanu- incident on 10/5/20 containing peanuts verified "R5 ordered sent the wrong one on 10/17/20, R5 red his menu, but a Mo peanuts was placed discovered in the n not receive the coo CSD-A verified ther culinary staff to kno items to ensure a re for which they were incident report had received food for w stated it would be a worker (SW). Wher	on 10/21/20, at 9:48 a.m. all food is made in the main elivered to the kitchen at the rred to it as "nursing care d some foods came from the uts in them and it was up to sure R5 did not receive them. requested a butterscotch bar 20, but received a scotch-a-rood d peanut butter. C-C did not urred. on 10/21/20, at 9:53 a.m. rector (CSD)-A stated en a paper menu at breakfast at day. For residents with food us were customized to include 0-A verified R5's menu listed uts. CSD-A was aware of the , when R5 received a dessert (a scotch-a-roo bar). CSD-A d the proper product, but we ." In addition, CSD-A stated quested an oatmeal cookie on nster cookie containing d on his tray. The error was ursing care kitchen and R5 did kie containing peanuts. re was nothing in place for ow specific ingredients in food esident does not receive food a allergic. When asked if an been completed when R5 hich he was allergic, CSD-A a grievance filed by the social n asked how the SW would ident, CSD-A stated he didn't				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	E CONSTRUCTION		E SURVEY PLETED
		00419	B. WING			C 23/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ΜΔΠΟΝΙ	NA TOWERS OF ROC	HESTER INC 4001 19	TH AVENUE NO	ORTHWEST		
MADON		ROCHE	STER, MN 559	01		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 945	Continued From pa	age 50	2 945			
	SW-A stated she h scotch-a-roo bar m leader meeting. SV person who discov incident report, add nursing." During an interview the director of nurs aware R5 received peanuts on 10/5/20 on duty that evenin and added, "I'm su DON stated she wo During an interview lead cook (LC)-B s main kitchen of the containers to nursii provided a docume week 1, Thursday" of food items to set document did not in food items, LC-B s responsible for det On 10/21/20, at 6:4 stood in the kitcher placed the entrees handed the plate to a tray and added c dessert items to ea food were delivered from the main kitch in steam wells. DA plated with plastic	v on 10/21/20, at 11:03 a.m. eard about R5 receiving the hade with peanut butter at a W-A stated it was up to the ered the event to fill out an ding "in this case, it was v on 10/21/20, at 11:09 a.m. ing (DON) stated she was no a dessert which contained D. The DON stated the nurse ng RN-B, was an agency nurs rprised I wasn't notified." The build follow up with RN-B. v on 10/21/20, at 6:35 p.m. tated all food was made in the facility and delivered in meta ng care for distribution. LC-B ent displaying the menu for "fa which indicated the quantitie nd to nursing care. While the ndicate ingredients for any tated nursing care was ermining resident allergies. 45 p.m. dietary aide (DA)-A n at the steam table, as he onto individual plates and o an aide who set the plate or old food, beverages and ach tray. DA-A stated pans of d to the nursing care kitchen nen in steel containers and pu- A stated desserts arrived over the top, in a tall enclosed A stated staff looked at the	e e l all s			

AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:       C       C         00419       B. WING       C       10/23/202         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       4001 19TH AVENUE NORTHWEST ROCHESTER, IMN 55901       PPOVIDER'S PLAN OF CORRECTION (EACH OPERICTINCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX ROCHESTER, IMN 55901       PROVIDER'S PLAN OF CORRECTION (EACH OPERICTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY)       Or PREFIX         2 945       Continued From page 51       2 945       2 945         Individual resident's paper menu and diet card in cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R55 diet card indicated an allergy to nuts: cashews and peanuts.       2 945         DA-A stated he was working the evening of 10/5/20, when R5 received the soctch-a-roo bar. DA-A was unaware the kitchen brough to ver soctch-a-roo bars and stated he though the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving soctch-a-roo bars.       During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in soctch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and soctch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occu		ta Department of He	Ī				
00419         B. WING         10/23/202           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901         VINAG         0001           (X4) ID PREFX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL PREFX         IP         PREFX         CACH CORRECTION         0000           (24) ID PREFX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL PREFX         IP         PREFX         CACH CORRECTION         000           2 945         Continued From page 51         2 945         2 945         2 945         Individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, disikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.         2 945         Image: Cacheer Core Cacheer Ca			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         MADONNA TOWERS OF ROCHESTER INC       4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901         VMI ID PREEX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREEX REGULATORY OR LSC IDENTIFYING INFORMATION)       PREEX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       ON PREEX TAG         2 945       Continued From page 51 individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.       2 945         DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.         During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked			00419	B. WING			
MADDONNA TOWERS OF ROCHESTER INC         ROCHESTER, MN 55901           (X4) ID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         0           2 945         Continued From page 51         2 945         2 945           individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.         2 945           DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.           During an interview with dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	1			
INCLUES IEV, MN 53901         PMEENT TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NULST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OGRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       O COM DEFICIENCY)         2 945       Continued From page 51       2 945         individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.       D DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.       D During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked       D Hereix table	MADON	NA TOWERS OF ROC	HESTER INC				
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       CECH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COME         2 945       Continued From page 51       2 945       2 945       EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)       DEFICIENCY)         2 945       Individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.       DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.       During an interview with dietary staff on 10/271/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no on had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked       DA-B			ROCHES	TER, MN 559			1
<ul> <li>individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.</li> <li>DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.</li> <li>During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked</li> </ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
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among themselves that night and just decided they needed to be more careful. During an interview on 10/22/20, at 12:51 p.m. CSD-A stated after the first incident with R5 she "told staff not to change the menu on their own." CSD-A went on to say there was only one dessert that day and it was supposed to be butterscotch bars, but it was changed to		individual resident's order to plate the for cards included nam likes, dislikes and f verified R5's diet can nuts: cashews and DA-A stated he wan 10/5/20, when R5 m DA-A was unaware scotch-a-roo bars and looked like butters of went by the menual served and on 10/5 they were serving served and on 10/5 they were serving served and on 10/5 they were serving served aides (DA)-B, (DA) did not know there scotch-a-roo bars. to articulate the diff between butterscot bars. The dietary a with them following further stated there prevent it from occur receive new trainin among themselves they needed to be During an interview CSD-A stated after "told staff not to chan CSD-A went on to a dessert that day an	s paper menu and diet card in bod accurately. Resident diet ne, room number, allergies, bood preferences. DA-A ard indicated an allergy to peanuts. s working the evening of received the scotch-a-roo bar. the kitchen brought over and stated he thought the bars botch bars. DA-A stated staff to determine the food being 5/20, there was no indication scotch-a-roo bars. w with dietary staff on kimately 6:55 p.m., dietary -C and (DA)-D, indicated they were nuts or peanut butter in In addition, they were not able ference in appearance tch bars and scotch-a-roo ides verified no one had talked the incident on 10/5/20. They were no changes made to urring again, nor did they g. DA-B stated they talked that night and just decided more careful. w on 10/22/20, at 12:51 p.m. the first incident with R5 she ange the menu on their own." say there was only one nd it was supposed to be				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED
		00419	B. WING			C 23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE NO			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
2 945	Continued From pa	ige 52	2 945			
		hen asked how staff would ed peanut butter, he verified				
	dated 2012 indicate					
	for each resident re	roved alternative) is provided eceiving meals from the				
		epartment, to ensure that meal ian diet order and that likes,				
	dislikes and individ	ual special needs of the				
	resident are being The culinary service	es director is responsible for				
		ate tray card for each resident, g to physician order, and				
	which contains the					
	information, update Name (first ar					
	Room numbe					
	Diet exactly a Beverage pre	s physician ordered				
	Food preferer	nces				
	Known food a					
	substitute)	s (e.g., adaptive devices, salt				
	The tray card w	vill remain with the throughout the meal service."				
	The immediate jeor	pardy that began on 10/5/20,				
	was removed on 10	0/22/20, at 6:00 p.m. when it				
		rough observation the facility new process to ensure				
	residents were not	served food for which they				
		were observed to conduct a uddle to review resident diet				
		was added to diet cards to				
	bring attention to fo	ood allergies. Review of diet				
		nus were followed by staff to to resident food allergies and				
	anartmant of Llasth					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			С
		00419	B. WING			23/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
ADONN	A TOWERS OF ROC	HESTER INC	HAVENUE NO TER, MN 5590	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 945	Continued From pa	ge 53	2 945			
	which contained kn labeled in order for addition, the facility food allergies on di- identified in the rest record. Staff educa- identification policy cards, began on 10 be conducted prior staff worked. A cor been established to changes. Lastly, an culinary manager of verify they were action	g meal service, food items own resident allergens were staff to avoid serving them. In conducted a verification of et cards against food allergies ident's electronic medical tion on the meal tray , including utilization of diet /22/20, continuing for staff to to the next scheduled shift nmunication book for staff had b identify resident diet a audit was conducted by the r designee, of diet cards to curately labeled for diet allergens. Audit results were lity council.				
	The director of nurs and revise policies assistance with eat education related to use require special director of nursing of audit tool to ensure assistance and equ promote resident in	THOD OF CORRECTION: sing, or designee, could review and procedures related to ing and provide staff to the care of residents who diets related to allergies. The or designee could develop an appropriate appropriate ipment are provided to dependence. R CORRECTION: Twenty-one				
	(21) days	Contraction. Twenty-One				
21520	MN Rule 4658.130 Pharmacy Services	0 Subp. 1-4 Medications and ; Definition	21520			12/4/20

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		00419	B. WING		10/2	23/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N TER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21520	Continued From pa	ae 54	21520			
21020	Subpart 1. Control substances" has th	led substances. "Controlled e meaning given in Minnesota 52.01, subdivision 4.	21020			
	means drugs with a have established m	II drugs. "Schedule II drugs" a high potential for abuse that nedical uses as defined in a section 152.02, subdivision				
	services" means se acquiring, receiving drugs to meet the r	acy services. "Pharmacy ervices to ensure the accurate I, and administering of all leeds of each resident.				
		egimen. "Drug regimen" ed and over-the-counter lent is taking.				
	by: Based on interview facility failed to ens were available for a	ent is not met as evidenced and document review the ure resident's medications administration per physician sidents (R1 and R9) reviewed rs.		Corrected		
	Findings include					
	10/23/2020, include failure, alcoholic cir 1, dementia withou constipation. R1's e 8/4/2020, included	ovided by the facility on ed diagnoses of hepatic rhosis of liver, diabetes type t behavioral disturbance, and elimination care plan dated is taking lactulose; goal of 2-3 per day due to cirrhosis.				
	R1's physician orde -Lactulose solution	ers included: 30 ml three times a day for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	
	00419		B. WING			23/2020
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	H AVENUE NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21520	Continued From pa	age 55	21520			
	tablets three times	milligrams (mg); administer 1-2 a day (start date 8/19/2020) ondroitin 500-400 mg twice a	2			
	identified multiple of given related to the -8/4/2020, MAR- or drug/item unavailat -8/5/2020, MAR - 3 administered: drug, -8/6/2020, MAR - 2 administered: drug, -8/30/2020, MAR - drug/item unavailat -9/15/2020, MAR - drug/item unavailat	<ul> <li>of 3 doses were not</li> <li>/item unavailable.</li> <li>of 3 doses were not</li> <li>/item unavailable.</li> <li>2 of 3 doses not administered</li> <li>ole.</li> <li>1 of 3 doses not administered</li> <li>ole.</li> <li>2 of 3 doses not administered</li> <li>ole.</li> <li>2 of 3 doses not administered</li> </ul>				
	administered: drug					
	administered: drug R9 R9's Face Sheet pr 10/23/2020, include hypertension, veno the liver, Chronic k	/item unavailable. rovided by the facility on ed diagnoses of essential ous insufficiency, cirrhosis of idney disease stage 3, insufficiency, and secondary				
	R9's physician orde					

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED		
		00419	B. WING			23/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ADON	NA TOWERS OF ROC	HESTER INC	FH AVENUE NO STER, MN 5590	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21520	- 1	0	21520			
	lipoderm cream, ap topically two times -Nystatin powder 1 application four tim 9/21/2020) -Hydrocortisone cre Ketoconazole and twice a day (start d 10/3/2020) R9's medication ad identified the medic	etamine 5% -lidocaine 2% in oply to bilateral knees 1 gram a day (Start date 9/28/2020). 00,000 unit/gram; one es a day (start date eam 2.5% Mix 1:1 with apply to the effected area ate 9/21/2020, stop date lministration record (MAR) cated cream/ointments were minister per physician orders.				
		stration record (MAR) on tion was not administered;				
	administered; phar drug/item unavailal MAR 9/22/2020, 4 administered; drug MAR 9/23/2020, 1 administered; drug	of 4 applications not /item unavailable. of 4 application not /item unavailable. of 4 applications not				
	administered; drug, med unavailable, a MAR 9/22, 9/23, 9/ applications were r unavailable	am of 2 applications not /item unavailable new admit nd pharmacy won't send. 24, 9/25/2020, 2 of 2 not administered; drug/item of 2 applications not				

AND PLAN OF CORRECTION		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED C		
		00419	B. WING		10/23/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	NA TOWERS OF ROC	HESTER INC	TH AVENUE NC STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21520	Continued From pa	ige 57	21520			
	<ul> <li>administered; drug/item unavailable.</li> <li>MAR 9/27/2020, 1 of 2 applications not administered; drug/item unavailable</li> <li>MAR 9/30/2020, 1 of 2 applications not administered; drug/item unavailable.</li> <li>MAR 10/2/2020, 1 of 2 applications not administered; drug/item unavailable.</li> <li>During an interview on 10/19/2020, at 9:37 a.m. trained medication assistant (TMA)-B stated if a medication was not available then then supposed to let the nurse know; if it's not ordered then we are supposed to order it. TMA-B indicated an unawareness if it was considered a medication error if the medication was not available from pharmacy.</li> <li>During an interview on 10/20/2020, at 11:16 a.m.</li> </ul>					
	director of nursing were not available considered a medic medication error re	(DON) indicated if medications for administration, it was cation error. The DON stated a port should have been sician should have been	6			
	Allixa pharmacy teo medications were of was a medication r just give when the confirmed pharmac available 24/7, how to communicate the immediately. PT sta have the medicatio	on 10/21/2020, at 2:35 p.m. chnician (PT) stated delivered to the facility, if there not available then staff would medication was available. PT cy delivery services were vever facility staff would have ey wanted the medication ated if the pharmacy did not n, facility staff should notify ision of medication was tion error.				
	During on interview	/ on 10/22/2020, at 9:34 a.m.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00419				C 23/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ADON	NA TOWERS OF ROO	HESTER INC	TH AVENUE NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21520	Continued From pa	age 58	21520			
	medication was no medication error an notified. LPN-A ind contacted. LPN-A is did not have the m the back-up pharm 10/23/2020, at 8:30 (DON) stated if a n for administration t be notified. DON si pharmacy and a ba	hurse (LPN)-A stated if a t available it was considered a nd the nurse should be icated the pharmacy should be stated if the primary pharmacy edication then we would call acy. 0 a.m. director of nursing nedication was not available hen the physician needed to tated the facility had a 24/7 ack-up pharmacy; medications e for administration when they	3			
	at 3:30 p.m. with n indicated an expect facility for administ expected to be not available. NP-B inc	one interview on 10/29/2020, urse practitioner (NP)-B, NP-B station medications were at the ration per physician order and ified the medication was not dicated an unawareness that not administered because it				
	dated 9/2018, inclu the medication deli order listing/ticket. noted the nurse no follow the direction correcting any error completed on the p	ivery of Medications policy uded 2. The nurse reconciles ivered against the pharmacy 3) If any discrepancies are stifies the pharmacy. Nurse will s of the pharmacy for orDocumentation will be oharmacy order ticket. 6. ations completed if medication				
		l of Correction: The signee could review the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00419 B. WING			C <b>10/23/202</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	TH AVENUE NO STER, MN 5590	-		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE	COMPLET DATE
21520	Continued From pa	ge 59	21520			
	the delivery of med Provide training for staff regarding thes	d revise systems to improve ications for each resident. pharmacy staff and facility e systems and could monitor very system to assure				
	TIME PERIOD FOF days	R CORRECTION: Thirty (30)				
21545	MN Rule 4658.1320	0 A.B.C Medication Errors	21545			12/4/20
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refe purposes of this pa (1) a discrepan prescribed and what administered to res (2) the administ medications. B. It is free of a error. A significant (1) an error v discomfort or jeopa safety; or (2) medication usually requires the blood to be titrated single medication e precipitate a reoccu	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of its Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. Fo rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired	S T			

Minnesota Department of Health STATE FORM

243111

If continuation sheet 60 of 87

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/23/2020	
		00419	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	I AVENUE N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page 60 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.		21545			
	by: Based on observative review, the facility for residents (R1 and for management were care in accordance practice. This practive insulin administration of the primmediate jeopardy. The immediate jeopardy the immediate jeopardy of the formation of the primmediate jeopardy. The immediate jeopardy for the prevention of the J on 10/21/2	ent is not met as evidenced ion, interview and document ailed to ensure 2 of 2 R4) reviewed for diabetic provided adequate diabetic with current standards of ice, including inaccurate on, inadequate monitoring and hysician, resulted in an y situation for R1. bardy began on 8/5/20, when ent care due to hypoglycemia level) due to a failure of the assess the resident's diabetic ntified on 10/21/20. The tor of nursing, interim infection culinary director were notified 20, at 12:45 p.m. The IJ was 20, at 5:45 p.m., but		Corrected		

Minneso	ta Department of He	ealth				APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		C 10/23/2020	
	00419		B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MADONN	A TOWERS OF ROC	HESTER INC	H AVENUE NO	-		
	SUMMARY ST	ROCHES	STER, MN 559	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21545	Continued From pa	age 61	21545			
		mained at a lower scope and a pattern with actual harm but opardy.				
	In addition, the facility failed to ensure appropriate indication for Lactulose and failed to administer per physician orders for 1 of 3 residents (R1) reviewed for medication errors.					
	Findings include:					
	diabetes, hepatic [l	ncluded diagnoses of type 1 iver] failure, alcoholic cirrhosis nentia without behavioral				
	assessment dated severe cognitive im with eating, and ree 8/24/20, indicated,	nimum Data Set (MDS) 8/7/20, indicated R1 had ppairment, was independent quired insulin. MDS dated R1 required one person supervision for eating.				
	indicated R1 had ty insulin. R1 goals in	plan revised on 8/27/20, /pe 1 diabetes that required ncluded, "Will have no elated to] diabetes and blood				