

Electronically delivered January 6, 2021

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 November 17, 2020, we notified you a remedy was imposed. On December 30, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 4, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective December 2, 2020 be discontinued as of December 4, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 17, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 23, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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



Electronically delivered

January 6, 2021

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

Re: Reinspection Results

Event ID: 243112

Dear Administrator:

On December 30, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 23, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

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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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04-8.html

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mishing

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001	ET ADDRESS, CITY, STATE, ZIP CODE 19TH AVENUE NORTHWEST HESTER, MN 55901	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS	F 0	00			
	survey was comple complaint investiga NOT to be in compl	10/23/20 an abbreviated ted at your facility to conduct tions. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
	SUBSTANTIATED: H5153039C, with d F760 H5153040C, with a H5153041C, with d F684, F688, F725,	eficiencies cited at F755 and deficiency at F684 eficiencies cited at F585, F755, F760, and F806 eficiencies cited at F725,					
	The following comp substantiated H5153042C H5153045C	laints were NOT					
	The survey resulted Jeopardy's (IJ):	d in the following Immediate					
	and identify respira were associated wi thrombosis or pulm immediately notify t worsening respirato	facility failed to monitor/assess tory change in condition that th worsening deep vein onary embolism and failed to the physician in the setting of ory distress. The IJ began on mediacy was removed on					
	insulin administration hypoclycemic even saving medication a	ts that required emergency life and hospitalization. The IJ					
ABURATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	VALURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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

11/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245153	B. WING _		10/2	; 3/2020
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F 000	on 10/22/20. 3) F806, when the fresident with a food food with the allerge and the immediacy. The above findings quality of care, and conducted on 10/22. In addition, a COVII Control survey was your facility by the Mealth to determine Infection Control. The in compliance. The facility's plan or as your allegation of Department's acception and the CMS-25 submission of the Everification of computation of computation of computation of computation of computation of conducted to validation of conducted to	facility failed to ensure a lallergy was not served the en. The IJ began on 10/5/20, was removed on 10/22/20. constituted substandard an extended survey was and 10/23/20. D-19 Focused Infection conducted on 10/23/20, at Minnesota Department of a compliance with §483.80 the facility was determined to the form the other compliance upon the other compliance upon the other compliance upon the other compliance upon the other compliance. Incolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as liance. Coc will be used as liance. Coc will the compliance of the that substantial compliance in the been attained in	F 00			
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST OCHESTER, MN 55901	107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 585	§483.10(j)(1) The regrievances to the fathat hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beharesidents, and othe LTC facility stay. §483.10(j)(2) The rethe facility must materiality to resolve grandous have, in accordance for the resident. §483.10(j)(3) The facility to resolve grandous file a griet to the resident. §483.10(j)(4) The facility and the grievance policy to of all grievances recontained in this paraprovider must give to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonymof the grievance offican be filed, that is, address (mailing ar number; a reasonal completing the reviews and the second completing the reviews and th	ge 2 esident has the right to voice acility or other agency or entity es without discrimination or ances include those with treatment which has been as that which has not been vior of staff and of other reconcerns regarding their resident has the right to and ke prompt efforts by the ievances the resident may e with this paragraph. acility must make information evance or complaint available acility must establish a ensure the prompt resolution garding the residents' rights aragraph. Upon request, the a copy of the grievance policy e grievance policy must at individually or through ent locations throughout the offile grievances orally or in writing; the right to file mously; the contact information icial with whom a grievance his or her name, business and email) and business phone only expected time frame for the work the grievance; the right decision regarding his or her	F 5	85			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		1072	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 585	grievance; and the independent entitie be filed, that is, the Quality Improvement Agency and State L program or protectic (ii) Identifying a Grieresponsible for overprocess, receiving a through to their connecessary investigate maintaining the conassociated with grie identity of the reside submitted anonymous grievance decisions coordinating with stanecessary in light of (iii) As necessary, the prevent further poteright while the allegate investigated; (iv) Consistent with reporting all alleged abuse, including injand/or misappropria anyone furnishing sprovider, to the admas required by State (v) Ensuring that all include the date the summary statementhe steps taken to its summary of the per regarding the reside as to whether the gonfirmed, any corrections.	contact information of s with whom grievances may pertinent State agency, and Organization, State Survey cong-Term Care Ombudsman on and advocacy system; evance Official who is reseing the grievance and tracking grievances clusions; leading any ations by the facility; fidentiality of all information evances, for example, the ent for those grievances ously, issuing written at the resident; and ate and federal agencies as a specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and		585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245153	B. WING _		10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	(vi) Taking appropriaccordance with St of the residents' rigior if an outside entithe State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining eviresult of all grievanthan 3 years from the decision. This REQUIREMENT by: Based on interview facility failed to ensicall-light wait times resolution for 6 of 6 R13, R14, R15) revice complaints of assist response time. Findings include: During document rewere reviewed for the of those 68 grievar length of time it too call lights. During document remeeting minutes from the meeting was a including R12, R13 included social wor administrator. Minutes from the meeting minutes from the meeting minutes from the meeting minutes from the meeting was a including R12, R13 included social wor administrator. Minutes from the meeting m	ge 4 itten decision was issued; ate corrective action in ate law if the alleged violation into its is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement atal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the designer of the grievance IT is not met as evidenced and document review, the dure grievances related to long were acted upon for timely residents (R7, R11, R12, iewed with ongoing tance with care and call light eview, 68 resident grievances and exist or respond to resident eview, resident council for 7/31/20, were reviewed. Itended by seven residents and R15. Staff in attendance for (SW)-A and the previous tes indicated residents voiced ights not being answered in a	F 58	R7 is no longer in the facility R11 was interviewed regarding ca response times and has no new c and will continue to be interviewed regarding call light response time. will be included in the weekly audi R12 was interviewed regarding ca response times and has no new c and will continue to be interviewed regarding call light response time. will be included in the weekly audi R13 was interviewed regarding ca response times and reported "it is somewhat better". R13 will be incl the weekly audit. R14 was interviewed regarding ca response times and has no new c and will continue to be interviewed regarding call light response time. will be included in the weekly audi R15 was interviewed regarding ca response times and reported staff better at acknowledging call lights	oncerns d weekly R11 t. Ill light oncerns d weekly R11 t. Ill light uded in Ill light oncerns d weekly R11 t. Ill light oncerns d weekly R11 t. Ill light are	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	(X5) PLETION DATE
F 585	concern if there wa too long for staff to reply read, "Shared doing to help staff a and shared that hu hard to recruit staff identified in the mir. During document remeeting minutes froidentified) were revattended by 15 resigned and the current indicated concerns the floor, especially p.m.; call lights being answered, call light the toilet too long, sthey are supposed plan of action to ad R12's quarterly Mirassessment dated cognitively intact. In 10/19/20, at 10:58 always come when adding, "Nothing mat night and it's dar stated, "They always ay 'I'll be right back R12 stated, "I'll be words; they don't costart out using my but my kids say do fall." R12 stated lor	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 588	returning more promptly. R15 will included in the weekly audit. All residents who reside at Mador Towers have the potential to be a "Concerns and Grievances" polic reviewed and remains current. Al be educated on the Concerns and Grievances policy and the 4 Call at the nursing staff trainings on 12 12/2. Project scope worksheet ha completed for the call light resport that includes the problem, the assassigned to complete the PDCA a problem statement data based go 4 Call system implemented by 12 Resident Council held on 11/19/2 Audits of customer concerns and response time will be completed for 4 weeks. Administrator/Designee is responsed to monitoring shall be reposed the facility Quality Council meeting ongoing frequency and duration the determined through analysis and of results.	nna ffected. y was I staff to d system 2/1 and is been nse time sociate and bal. /4/2020. 020. call light 3x/week sible for ported at g with o be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONST			COMPLETED				
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIF 4001 19TH AVENUE NORTHWES ROCHESTER, MN 55901		101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 585	about it. According minutes, R12 attended september 2020, more sponse time conded R14's quarterly Minus assessment dated cognitively intact. D10/19/20, at 1:13 pmy light on and wait prune juice and whose I try and go by mon my own that I'm stated when long cabrought up at reside and the administrate changed the subjectit." R14 stated, "It wallowed to say much stated, "They say it but it's far from it." A meeting minutes, R2020, meeting whe concerns were rais. A grievance report call light was on for seven days, R14 haminutes. Of those, and of those, one word of the seven designation of th	to resident council meeting ded the 7/31/20 and neetings where call light cerns were raised. Simum Data Set (MDS) 10/6/20 indicated R14 was puring an interview on m. R14 stated, "I can have at 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 for backed away from it and ct. He didn't want to talk about was evident we were weren't h as he cut us off." R14 's supposed to be our home, According to resident council at attended the September re call light response time		585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		/23/2020	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 585	assessment dated cognitively intact. D 10/19/20, at 2:09 p wait 10 minutes for "Today I waited 40 "Personally, I have consequences of h answeredyet." Raresident council me response time was said, "We'll take calback from them." A meeting minutes, R September 2020, n response time cond. A grievance report reported her call lig answered: used to 20 minutes. The (proposed to R13 and informe some changes with getting more people The administrator wanderstanding that full-time staff dropp return to school, but everything they counter the same conditions and on this to waiting for some	nimum Data Set (MDS) 9/29/20 indicated R13 was During an interview on .m. R13 stated she used to her call light to be answered, minutes." R13 stated, not suffered any aving to wait for call light to be 13 stated she attended setings where call light discussed and management re of that but we don't hear according to resident council 213 attended the 7/31/20 and neetings where call light beens were raised. dated 7/31/20 indicated R13 whith took too long to be be 10 minutes and now were revious) administrator spoke at R13 that there would be a staffing with the goal of e on the floor at busy times. 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	F 5	85			

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ľ	COMPLETED	
		245153	B. WING			C 10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	DDE		0,2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD E	3E	(X5) COMPLETION DATE
F 585	were reviewed for 8 lights for R13, one would be some chargoal of getting more times. The administ understanding that full-time staff dropp return to school, but everything they cousame 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 bathroom. FM-F stand told her R7 pus was responding. At facility and no one ap.m., FM-F's relative one answered the pacalled R7 back and yet. At 6:51 p.m., Fand a male answered the phone with R7 in room at 7:00 p.m." #2, but I think she hangry and frustrated and heart breaking and you can't help.' the administrator or	ge 8 8/3/20, and out of seven call was over 20 minutes. The rator informed R13 there anges with staffing with the expeople 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 that the facility was doing all to recruit staff. NOTE: the way up for the grievance dated do to this grievance dated do to this grievance dated do to this grievance dated do to the steel R7 called her at 6:30 p.m. shed her call light but no one 6:37 p.m., FM-F called the answered the phone. At 6:40 the called the facility and no ohone. At 6:50 p.m., FM-F learned staff had not arrived M-F called the facility again the down 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 held it." FM-F stated she felt down the phone about this on the phone about the phone about the phone ab	F.5	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001	EET ADDRESS, CITY, STATE, ZIP CODE I 19TH AVENUE NORTHWEST CHESTER, MN 55901	10/2	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 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, "Staso long and leaders it but we don't see of R15's quarterly Min assessment dated cognitively intact. D 10/20/20, at 4:27 p. couple of times who minutes to be answere concerned there couple of times who minutes to be answere concerned there coupled in the property of the	l've ever had with a human d, "We are speaking up not all the residents there, my em." simum Data Set (MDS) 10/11/20 indicated R7 was ruring an interview on 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." imum Data Set (MDS) 8/14/20 indicated R15 was ruring an interview on ed m. R15 stated there had en call lights took 50 and 60 rered. R15 stated, "I'm ruld be a medical emergency know it. A lot can happen in an all light response times have resident council meetings but according to resident council entity and neetings where call light	F 5	885			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING				23/ 2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZII 4001 19TH AVENUE NORTHWES ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 585	told FM-I that it take her to bed, that she supposed to. FM-I swas worried if R15 emergency. FM-I st concern when R15 but it was now. FM-her concerns. According to a grieve FM-I called the faci had been long and be hired. FM-I expressive from the second of the second	es staff such a long time to put transfers herself and was not stated, "She gets tired." FM-I	F 5	585			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	COMPLETED		
		245153	B. WING			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 DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 585	like everyone else i call the facility to as just falls on deaf ear overwhelmed and swhat's happening the A grievance reporter reported waiting a lespecially on 9/18/2 bathroom. It was not concern about falling the bathroom. Grieved documented by the R11's call lights for Of those 23, the gries-six were over 20 resix were over 20 resi	p herthey are understaffed s." 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 and use to self-transferring to wance investigation findings a DON indicated a review of 9/18/20, and there were 23. In evance report indicated: minutes are over 50 minutes are	F 5	85				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				STREET ADDRESS, CITY, STATE, ZIF 4001 19TH AVENUE NORTHWES' ROCHESTER, MN 55901		10/1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFI TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 585	baths on evening a less nursing assistates residents and answ. During an interview trained medication not aware of a specilights were to be an say not longer than. During an interview registered nurse (R the facility for two medication and the facility for two medicates." During an interview DON stated it was the resident call lights they have been work assurance. DON stated it was longer than 15 we get a complaint is investigated." DOT through call light logdid, however she were administrator stated lights be answered Administrator admit call light logs; the quadministrator was medicall light responses he would ask resides.	and weekends and this meant ants on the floor to assist ver call lights. I on 10/19/20, at 2:21 p.m. aid (TMA)-A stated she was being time frame in which call aswered and stated "I would 20 minutes." I on 10/19/20, at 2:57 p.m. N)-C stated he has been at months did not recall anyone ame in which call lights should dded, "not longer than 15 or an 10/20/20, at 7:45 a.m. the facility goal to answer before 15 minutes, adding rking on this with quality atted she realized at times it minutes. DON stated, "When about a call light response, it on stated she has not looked gs, but their quality person as on a leave of absence. I on 10/20/20, at 8:30 a.m. the dis expectation was for call	F	585			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245153	B. WING			10/2	23/2020
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL				STREET ADDRESS, CIT 4001 19TH AVENUE N ROCHESTER, MN	ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFI TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	During an interview (RN)-A stated call li answered in under assistants. RN-A stanswered in 10 min ask if they could an the NA needed help. During an interview with administrator acall light grievances council meetings wadministrator state it," adding, "the long meal times and had Administrator state place to address the articulate the meas an action plan to actimes, administrator of action plans I can administrator stated move forward with the "we're making prog. The Administrator prelated to resident gresponse times. Do 1. 7/27/20, quality a improvement (QAP notation regarding a on call lights, which satisfaction from 37 decrease call light minutes will decrea 2. 8/24/20, QAPI measured in under the state of	on 10/20/20 at 9:42 a.m. ghts were supposed to be 10 minutes by the nursing ated if a call light was not autes, she radioed the NA to swer the call light or asked if b. on 10/20/20, at 10:49 a.m. and SW-A, when asked how a brought up at resident ere addressed, the d, "I was there and addressed g call light times were around I to do with Covid restrictions." In they had put measures in them, but was not able to aures. When asked if there was aldress the call light response or stated, "There are all kinds in show you." The lift was hard for the facility to the change in leadership, but	F 5	85			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	HESTER INC		4001 1	TADDRESS, CITY, STATE, ZIP CODE 19TH AVENUE NORTHWEST HESTER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	on call lights which 50 % by 9/30/20. 3. 9/28/20, PowerP Monthly QAPI 9/28/ and an action plan. specific steps, (e.g. reduce call light resersidents, reviewed June 2020, staff moverification these acresponse times had a new call light syst of 10/31/20. During an interview with DON and SW-more unhappy reside evidenced by an incompany families almost daily unhappy families are verbalized example members: 1) My mom fell; what is the mom's portal and I and no one has conwindow and mom distated she tried to get the reapy and got back possible. According meetings with human aren't getting application burned out." DON stated, "Staff to do that day; nother service of the reapy and got back possible. Staff to do that day; nother service of the reapy and got back possible. Staff to do that day; nother service of the reapy and got back possible. Staff to do that day; nother service of the reapy and got back possible. Staff to do that day; nother service of the reapy and got back possible. Staff to do that day; nother service of the reapy and got back possible. The reapy and got back possible possi	ge 14 read: primary goal: 37.5% to oint presentation titled (20, included data measures The action plan identified , teach multiple ways to ponse time, interview call light response times at eetings). There was no ctions to improve call light doccurred. The target date for 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 I voicemails and emails from yThere are so many and complaints." SW-A s of concerns from family om was left on the toilet 2) My e update? 3) I looked in see she ran a temperature intacted me. 4) I went to her idn't eat her lunch. SW-A get a report from nursing and ck to family as soon as i to the DON, there are daily an resources and stated, "We eants and our current staff is stated staffing was taking all ing else was getting done. ijust get done what they have ing is being improved." DON provide the care residents	F 5	85			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD THE APPROPR	BE CO	(X5) MPLETION DATE
F 585	deserve." DON ver light response policilight response time those periods could During an interview NA-B stated, "We're lights in 15 minutes stated there was not During an interview with corporate vice (VPO)-G and admir extensive grievance light response time, medications not addiconcerns (incorrect The administrator s action plan to addre aware of all of the gresidents, only those The administrator s position in 2/2020, then Covid hit, then clinical managers of the c	iffied there was no facility call y to indicate expected call for staff and what to do if I not be met. on 10/20/20, at 4:45 p.m. e supposed to answer call , 5 minutes preferably", but of enough staff to do that. on 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 food; food not warm enough). tated there was a call light ess call lights. VPO-G was not prievances and concerns of e that rose to a certain level. tated when he took the they had the state survey, the DON was terminated and uit so have been trying to	F 5	585			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	this and reminded to complete it. Finding documented and ta Facility policy titled dated 2017, indicat Purpose was to creresident and custor readily resolved. 1. A resident/reside to voice grievance discrimination or re 2. The term "voice formal, written grievinclude a resident's Concerns and grievanonymously. 3. The community primary method to expectations. In ketrained to obtain an representative cust 4. We do not tolera 5. We respect reside. We encourage reemployees to raise 7. The community a concern, there is a associates to acknown concern, investigate the resident appropriate to the community of the c	r delegate it. SW-A monitored the assigned person to gs and follow up are alked about at QAPI. Concerns and Grievances, ed: the and environment where mer concerns are solicited and ent representative has the right and concerns without prisal. Concerns" is not limited to vance process, but may be verbalization to staff. Vances can be made eviews customer concerns as a learn of and meet customer eping with this belief, staff is ad respond to resident/resident omer concerns.		35		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	NG	` '	TE SURVEY MPLETED
		245153	B. WING		10	C / 23/2020
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 585	10. When a concer completes a concer social services dep 11. Social worker p 12. The administrat designee review co 13. A summary of c quality council. Dat compared to nation and opportunities for opportunity for improa. related proceprobably cause ide b. an action pla measurable goals a target. c. action plan is d. follow up rep quality council regal 14. Community will demonstration the incomplete social services and the control of the	is voiced to staff, staff rn form and forwards it to the artment. rocesses the concern. tor and social services impleted concern forms. concerns is reviewed at the a is trended over time and hal averages to detect patterns or improvement. If an rovement is identified: esses are reviewed and a nified in is developed with timelines, and person(s) responsible implemented forts are presented at the arding effectiveness of the plan maintain evidence of results of all grievance for a an 3 years from the issuance	F 5	35		
	2017, indicated: Purpose was to promeet and provide a to listen and respondencerns. 1. When a resident listens to resident groncerns and record The facility serious recommendations at these recommendation practicable, in developments.	Resident Council, dated ovide for resident groups to a forum of facility management and to resident ideas and group exists, the facility group views, and acts up the mmendations of the residents. By considers the group and attempts to accommodate attempts, so the extent eloping and changing facility esident care and life in the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245153	B. WING			C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
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F 585	facility. The facility of the resident group. 2. Minutes are main provided, or access 3. The facility demo	communicates its decision to	F 5			12/4/20
SS=J	S 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents recei accordance with propractice, the compresare plan, and the raths REQUIREMENT by: Based on interview facility failed to mor condition, and failed for 1 of 1 resident (1)	fundamental principle that lent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered	FO	R2 is no longer in the facility. R8 is no longer in the facility. R9 is no longer in the facility. All residents on hospice, those	with fluid	12/4/20
	with a potential for the lungs). As a resimmediate jeopardy for R2 who had disp with significantly low requiring an increast transfer to the hosp. The immediate jeopathe facility did not so and was identified on the lungs.	bulmonary emboli (PE, clots in sult of the facility's failures, an (IJ) situation was identified blayed respiratory distress woxygen (O2) saturations, se in oxygen and emergent ital emergency room (ER).		restrictions, and all those on oxy the potential to be affected. "Change in Condition" policy wa reviewed and remains current. "Benedictine Standing House O Symptom Management", which bowel management protocol wa reviewed and remains current. "Administering Medications" pol reviewed and remains current. "Comprehensive Assessments a	rgen have rders for includes s	

	A. BUILDING		SURVEY PLETED				
		245153	B. WING				23/2020
NAME OF F	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2020
					001 19TH AVENUE NORTHWEST		
MADONNA TOWERS OF ROCHESTER INC					OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	social worker (LSW infection preventior immediate jeopardy The immediate jeopardy 10/22/20 at 5:45 p. remained at the low G - isolated, scope indicated actual har jeopardy. In addition, the facil assess for the use prevent constipation who had a diagnos hospice for end of I and evaluate signs overload and follow residents (R9) with (moderate) chronic Findings include:	ist were notified of the vat 12:45 p.m. on 10/21/20. Dardy was removed on m., but noncompliance ver scope and severity level of and severity level, which m that is not immediate lity failed to manage, monitor, of bowel medications to n for 1 of 1 residents (R8), is of constipation and was on ife care; and failed to monitor and symptoms of fluid v physician orders for 1 of 2 a diagnosis of stage 3 kidney disease.	F6	684	Planning" policy was reviewed and remains current. "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 policy emphasis on provider and responsions party notification and abnormal O2 and respiratory status. Licensed state be educated on the facility's Change Condition policy, Administering Medications policy, Comprehensive Assessments and Care Planning pand the Benedictine House Standin Orders for Symptom Management nursing staff trainings on 12/1 and Licenses nursing staff, as part of the abatement plan, were educated or sign/symptoms of pulmonary embodicensed nursing staff will be educated overload and bowel management with emphasis on assessment and documentation of effectiveness of	sment" current. ne the y with ible sats aff will ge in e olicy ng at the 12/2. ne i oli. ated on nent	
	moderate cognitive extensive assistance bed mobility and tra assistance from one and dressing. The I required oxygen, w medications, and have R2's Face Sheet, ir embolism, deep verower extremity (ad atelectasis (lung compared to specific product of the section	9/6/2020, indicated R2 had impairment and required be from two or more staff for ansfers and required extensive extaff for toileting, hygiene, MDS indicated R2 had not as administered anticoagulant ad a surgical wound. Included diagnoses of acute ing thrombosis (DVT) of right ded 9/14/2020), and Illapse) (added 9/1/2020).			documentation of effectiveness of medications and use of electronic record BM report at the nursing statrainings on 12/1 and 12/. All nurse be educated on the electronic heal record Bowel and Bladder Observa (assessments) at the nursing staff trainings on 12/1 and 12/2. All nurse assistants/TMAs will be educated point of care documentation for bomovements and Weight Monitoring Documentation policy at the nursing trainings on 12/1 and 12/2. Audits will be completed on O2 safe	nealth iff es will th ations sing on the wel y and g staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING				23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001 1	ET ADDRESS, CITY, STATE, ZIP CODE 19TH AVENUE NORTHWEST HESTER, MN 55901		
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F 684	following: Initiate ar 1-4 I/min (liters per PRN (as needed) for breath), hypoxia (Oupdate provider with R2's care plan date experienced hypertidentified to include ordered, check blood observe for signs of including; dizziness care plan did not account outlined in Require hospital Discharge vein thrombosis (A clots form in veins I and PE (pulmonary which a blood vessiby a blood clot). R2's hospital Discharded (Discharded 9/14/2020, holds a blood clot). R2's hospital Discharded (James Requiring Frincluded, Continue lower extremity for swelling, evidence (diminished pulse, new/worsening pair weakness) and any breath, chest pain, suggest evidence cembolism. Please was tolerated by pating R2's progress note	and titrate supplemental 02 at minute) via nasal cannula or dyspnea (shortness of 2 saturation <90%); and to h nursing assessment. Index 9/11/2020, indicated R2 dension. Interventions were administer medications as and pressure per order, and f high blood pressure so the pain, dyspnea. The address the instructions as a Follow Up section of the Summary to monitor for deep condition in which the blood ocated deep inside the body of embolism-A condition in the lung(s) gets blocked arge Summary Brief Overview and a section called, Active collow-up. This section close monitoring of the right propagation/worsening of of neurovascular compromise numbness/tingling, in the distal extremity, we evidence of shortness of and/or hypoxemia that may of possibility of pulmonary wrap lower extremity with low for swelling control symptoms	F 6	re Al more Au co Ell re Re mo Au foi 5x do co Re tho	spiratory status 5x/week for 4 well residents are currently on covid onitoring including vitals with satisfication and the spiratory monitoring. Judits for symptom recognition will ompleted 5x/week for 4 weeks will ectronic Medication Administration porting function - "Facility Activity aport" which includes bowel ovements, weights and fluid intalludits of nursing assistant document and the second will be compared to the second will be compared to the second will be reported the second will be reported through analysis and reference of the second will be reported through analysis and reference through analysis and reference through analysis and reference through the second will be results.	be the the converse of the con	

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	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901			
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F 684	continue to monitor skin assessment w coloration of right los surgery 5 centimeters. R2's physician visit recapitulation of hodischarge orders for right lower extremit signs/symptoms of worsening DVT, an note indicated nurs need when working physical therapy recoxygen for therapy shortness of breath tingling in the extrephysician would coincreasing oxygen. bluish coloration of right leg. The note is sounds and "3. Nur monitoring of right I diminished/loss of pnew/worsening pair weakness, shortnes and/or hypoxemia to pulmonary embolis. R2's progress note indicated a telephothe NP (nurse practincreased 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 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, oulse, numbness/tingling, in the distal extremity, as of breath, chest pain, hat may suggest possibility of	F 6	84			

	ND DLAN OF CORRECTION IN IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIF 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		1072	0,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE	
F 684	"PT [physical theral in w/c [wheelchair] refusing it. Pt on root to stand CGA [contifor 1 min [minute] w O2 and initially 92% decreased to 73% arebound. PT donne Stood 2nd time and finger and decrease [seconds] of standindown. Vital machinic cord retrieved to pluplace O2 at 78% ar >90%. O2 increase time and watched O20 sec and had pt secover. Reassesse back to room air and quickly above >90. to room air w/ pt at of pt desaturation we give meds." R2's progress note a.m.stood with PT flet patient stand lor Donned oximeter a entire stand. After set to 81% after sitting therapeutic rest at 15 seconds only as and made pt sit downeds."	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 // PT limiting time to assess // upon sitting and then and took about 1 min to d O2 at 1 lpm and O2 93%. If able to place oximeter on ed to 66% after about 45 sec and and had pt immediately sit to then had dead battery and ug in and by the time this took and then quickly returned to d to 3 lpm and pt stood 3rd O2 and decreased to 78% at stop. Pt took 1 min 20 sec to ed O2 SATS to do quick wean and at [sic] was in 80's and Monitored to 2 lpm, 1 lpm and 100% by end. Notified nurse // activity as nurse arrived to dated 9/17/2020, at 11:39 for 1 minute, and PT would not neger to ass O2 sats/tolerance. Ifter standing and O2>90% sitting, O2 eventually dropped for awhile and with 100%. Pt stood 2nd time and a O2 dripped to 85% quickly wn with O2 dropping to 74% or recover. Discontinued	F 6	84				

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F 684	a.m. indicated R2 of breath and did not 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%. I wheeled walker] an 25 sec of standing took 2 1/2 min to regoing to stand pt aguse toilet urgently a transfer quickly to k rest prior to toilet tradecreased to 49% onotified nsg [nursing toilet and updated a toilet>w/c transfer v changing and clear to 39% with O2 on recover >90%. Nurswithheld. At rest in 60's to 100% while R2's clinic registered note dated 9/18/20/2 received from nurse Towers, Resident when resident's 02 Room air sats were resident's 02 sats woxygen 3L on, ever no apparent distrescyanosis (bluish distant).	dated 9/18/2020, at 11:13 Idenied 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 to O2 SATSs for mobility and Pt stood CGA w/ FWW [front and decreased to 69% after just and had pt sit back down. Pt scover >90%. PT was not gain, however, pt requesting to and instructed pt on need to seep 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	F6	84		

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		245153	B. WING _			C / 23/2020	
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F 684	were getting the sa states readings were standing and sitting an S-bar be sent with remains on 3L of 02 R2's follow-up physical 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 or reported that the arrassessed her and for They stated that should be accorded to the ED. Nursing eye on her over the signs 3 times daily call if 02 drops <90 hospitalization) or it Assess for SOB [shrough, dizziness/ligpain or swelling where the signs are commended sent room for further evaluated her and cevaluated her and cevalua	ed with another machine and me kind of readings. She re "all over the place" at a positions. Writer requested ith updated vitals. Resident 2. Sician's note dated 9/18/2020, and "Called facility and talked to a sat reading was all over the low as 50% and they're acy of the equipment. Indmitted to [name of hospital] T. With concern for pulmonary order to send her back to	F 68	84			

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	PROVIDER OR SUPPLIER	HESTER INC		400	REET ADDRESS, CITY, STATE, ZIP CODE 01 19TH AVENUE NORTHWEST DCHESTER, MN 55901			
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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 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 [reside command. This AM body was very cold with extra blanket a oxygen was 56 eve Ambulance was call to the hospital." The the physician had be 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."	F 6	84				

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F 684	family member (FM had been at work a nurse at the facility indicated R2 may be room for non-emergarrived at the facility around 6:00 p.m. the of sending R2 to the had ordered an incituat on 9/25/2020, was put up R2's no resulted in not a huamount, R2 also has stated R2's death or "Complications of rihypertension, and A" 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 fawhen they were go participation in the composition in the composition of the progress notes and leave a lot of unans a lack of monitoring changes in color/was During an interview	n)-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 ad blood in her stools. FM-A	F6	684			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C / 23/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	orders, place on ox physician depender During an interview RN-B stated he was low oxygen saturative 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 charassessment dated been admitted to he impairment, and did behaviors. According extensive assistance members for bed muse. The MDS indicincontinent of bower R8's Face Sheet, in bowel syndrome, or R8's care plan date. Resident has a ter receiving hospice significant characteristics.	ons, would check standing ygen and call 911 and/or not upon situation. on 10/23/2020, at 5:03 p.m. is the nurse that found R2 with ons. RN-B stated it was an at the time and should have in and ambulance immediately. pardy was removed on in p.m. when it was determined re-education and it to licensed nursing staff on a of condition policy with it mal respiratory status and pulmonary embolism. In it developed and implemented for respiratory monitoring. N: nge Minimum Data Set (MDS) 7/23/2020, indicated R8 had ospice, did not have cognitive in the MDS, R8 required the from two or more staff pobility, dressing, and toilet cated R8 was always	F 6	84		

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F 684	comfortable as able with hospice for encincluded, Administed monitor and docum medication. Followneeded. The elimin 7/28/2020, indicate elimination related opioid medication with s/sx [signs/symptor review date" (goal of interventions included ordered and observed of the comfort/pain opioid bowel movement in protocol per standin Observe for s/sx of stools, abdominal benausea and/or vom (6/29/2020) assist of to/from toilet. R8's physician order-Morphine concentral as needed (PRN) beneeded for shortner 7/18/2020, end date -Lactulose (laxative PRN for constipation date 8/5/2020) -Lactulose 15 ml by take 15 ml daily as date 7/15/2020, end-Lactulose 30 ml two end date 8/11/2020 -Senna with Docust two tablets in the minimum and document of the constitution of t	e with through collaboration of of life care." Interventions of medications as ordered, and effectiveness of the power plan edited on the decreased mobility and with the goal of "will have no ms] of constipation through the dated 6/29/2020). The led, administer medications as we for effectiveness, see care plan (7/28/2020), If no of three days follow boweling orders (6/29/2020), constipation: passing hard/no ploating/swelling, cramping, atting, mental status changes of one stand pivot wheelchair ers included the following: rate solution 5 milligrams (mg) by mouth every hour as so of breath or pain (start date as 8/9/2020) and (start date 7/15/2020, end of mouth daily and may also meeded for constipation (Start date 8/5/2020) vice daily (start date 8/5/2020, vice daily (start date 8	F6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 684	7/28/2020), order we take 3 tabs twice a 8/11/2020Bisacodyl 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 to constipation if no redate 8/2/2020, end Miralax 17 grams of 8/5/2020, end date Facility standing orderector on 3/1/2019 Management included constipation; (Perforectal check to determine the bisacodyl supposite day for constipation Bisacodyl if no result enema per rectum constipation in the record consistently bowel assessments physical examination distention, presence abdomen. The record enedications were medications were medications were medications were medications were medications.	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 date 8/11/2020) gram/118 ml; 1 tube, one time order (7/26/2020) ube, every three days PRN for sults from suppository (start date 8/11/2020) nce a day (start date 8/11/2020) nce a day (start date 8/11/2020. ders signed by medical 20, for Bowel and Bladder led the following for rm step sequentially) Perform rmine if impaction is present, ory 10 mg per rectum twice a 10. Reattempt Senna or 11st after 24 hours. Fleets 12every 3 days PRN for 13esults from suppository. ministration Records (MAR), 15esults from suppository.	F6	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	medication was given R8's progress note R8 reported constip suppository and lax movement. R8's BMR identified movements on 7/23 One PRN dose of L7/25/2020; dose was effective, no further MAR indicated no Fadministered. 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. has consistency of BM v BMR. R8's BMR included - 7/27/2020, medium consistency identification -7/28/2020, no bow -7/30/2020, no bow -7/30/2020, no bow -7/31/2020, no bow Bisacodyl supposite and was not effective-8/1/2020, no bowe -8/2/2020, R8 had	dated 7/22/2020, indicated pation "relieved with atives" had large bowel R8 did not have bowel R9 did not have b	F6	\$84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001	EET ADDRESS, CITY, STATE, ZIP CODE 1 19TH AVENUE NORTHWEST CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	administered PRN effective8/3/2020, no bowe suppository and lad not effective8/4/2020, medium soft/formed. MAR in Bisacodyl administe - 8/6/2020, no bowe Miralax was admini bowel medications -8/7/2020, no bowe scheduled medicati administered and content there was no bowe administered morph bottom pain 5/10; reffectiveness8/8/2020, small bound hard; MAR idea for day 4 without a documented as efferecord lacked evide re-approached. R8 mg at 2:58 p.m. for have bowel movem and at 4:58 p.m. for have bowel movem and at	lactulose that was not all movement. PRN Bisacodyl stulose administered and was a bowel movement that was adicated lactulose and ered and were not effective. It movement; MAR identified stered per schedule, no PRN administered. If movement; MAR identified it movement; MAR identified it movement; MAR identified it movement; MAR identified it movement recorded. R8 was nine 5 mg at 4:52 p.m. for ecord lacked evaluation of it well movement that was dry intified Bisacodyl administered bowel movement; ective. R8 refused Senna S, ence after refusal R8 was was administered Morphine 5 discomfort when trying to lent and shortness of breath, rebottom pain.	F 6	84			

	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 PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC			4001 19TH	DORESS, CITY, STATE, ZIP CODE AVENUE NORTHWEST TER, MN 55901	1072	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	laxatives and Bisace Fleets enema giver Effective with media verbalized relief with note also indicated R8's progress note called to update on medication due to comedication due to comedicate due	odyl suppository ineffective. In as per standing order. Im hard stool. Resident In abdominal discomfort." The In abdominal discomfort.	F6	84			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245153	B. WING _			C / 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	indicated R8 report bowel medication is per hospice order with per hospice order with transferring, and distribution and via phone management. A sui included, "STAT velactulose PRN per placed." Note at 9: had a medium bow Results were common R8's progress note hospice at the facilia Bisacodyl 10 mg da 30 ml twice a day. A p.m. indicated staff bowel movement discomposition of the R8's progress note took her bowel and subsequent note at was applied to residuicated hospice with the supplementation of the R8's progress note took her bowel and subsequent note at was applied to residuicated hospice with the supplementation of the R8's progress note indicated hospice with the supplementation of the R8's progress note indicated hospice with the supplementation of the supplementa	dated 8/4/2020, at 1:09 p.m. ed constipation, scheduled uppository and enema given with small smeared results. en for comfort during care, scomfort due to constipation." hospice was updated during related to bowel beequent note at 1:46 p.m. rbal order for another hospice for constipation 54 p.m. included, "Resident el movement this evening." nunicated 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 nine 5 mg at 3:23 p.m. for did not identify the emedication. dated 8/8/2020, indicated pain medications. A 8:47 p.m. indicated cream dents bottom due to	F 68	34		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP O 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	CODE	10/20/2020
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 684	from hospice to sta ordered. The note is the pain medication subsequent note at refused her morning member was prese administered include "Resident started to involuntary constrict muscles of the intercreating wavelike montents of the can abdominal discomfigiven hourly per order management." The was contacted and R8's record lacked administration of both initially refused. R8's progress note indicated R8 had a when she was reported. R8's progress note (late entry document p.m.) included, "Re [complained of] pain administered pain ranxiety. "This writer suppository to her refusing oral bowel small bm's. Reside NO suppository." Room at the time an request. Hospice here	y on PRN medications as indicated R8 was administered as and had good results. A 4:04 pm. indicated R8 had g medications. Family int, asked medications be ling lactulose and senna. In have peristalsis (the stine or another canal, novements that push the all forward) which caused fort and pain. PRN morphine der with less effect on pain in note then indicated hospice increased morphine. Staffs re-attempt of owel medications after it was indicated 8/10/2020, at 5:51 a.m. soft small bowel movement esitioned. dated 8/10/2020, at 1:28 p.m. inted on 8/11/2020 at 1:40 sident restless and c/o in." Note indicated R8 was medication and Haldol for	F6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING _			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 DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	offer the suppositor refused. R8's hospice visit in "RN did rectal check rectal pain. [Name practical nurse] did requested by this R refusal. RN noted pand disimpacted XI was unable to comphave bleeding from (possible hemorrhorectal area to slow pt Dulcolax supposed sounds hypodisimpacted, she with grimacing or restless note also indicated to hospice house. During an interview nursing assistant (N supposed to record sometimes things of think there was a with NA-D stated the nursure residents had administer supposite every three days. During an interview NA-C stated NA's with the supposition of the supposition o	ge 35 ote indicated the nurse tried to by again and the resident ote dated 8/11/2020, included k due to complaints of having of nurse] LPN [licensed not give suppository as the not give supposite to pt rectum in moderate amounts and the not give supposed to give supposed to make the not give supposed to make bowel movements, lidn't get charted, and didn't give supposed to make bowel movements and the not give supposed to document the not give supposed to document the not give supposed to document however, needed work. NA-C	F 68	84		
	indicated agency st NA-C indicated a se	raff were not documenting. uppository was supposed to nt did not have a bowel				

	OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING		_	10/2	3/2020	
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC				STREET ADDRESS, CITY, STA 4001 19TH AVENUE NORTH ROCHESTER, MN 5590	IWEST	10/2	.0.2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE	
F 684	movement every the nurse to administer. During an interview licensed practical in were supposed to cand report to the numovement in 3 days constipation. LPN-A with nurses prior to an assessment to be physician's orders as medications. If a be effective, then more defective, then m	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 arse if haven't had a bowel so rif resident complained of A stated TMA's have to check holding any medications for the completed. LPN-A stated should be followed for bowel owel medication was not a follow-up was required. on 10/21/2020, at 12:16 p.m. N)-A stated there was a bowel meet. RN indicated the report a pulled up during the shift; if the intervention of the administration of bowel when a resident would action. on 10/21/2020, at 3:03 p.m. N)-C stated a complete bowel be completed and of the administration of icated if no bowel movement osed to get a suppository, and aults then more intervention	F6	84				

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C / 23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	it was left up to the determine difference small/medium/large. During an interview director of nursing and confirmed physical management were nursing should have per physician order documenting refusa administer, if a TM/s should have reported what happened. Do should be completed constipation and/or medication. During a return phosical attention and stated staff should medications per ordenema should not be prescribed medicate expectation that nursessments daily concerns and before medications. R9 FLUID OVERLOR. R9's admission Minassessment dated not have cognitive in extensive assistant.	documentation and indicated person recording to e between s. 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 s. DON stated they should be als and need to re-attempt to a documented refusals they ed to a nurse and document DN stated bowel assessments ed when complaints of before administering a PRN one interview on 10/29/2020, arse practitioner (NP)-B, NP-B one administering bowel ders. NP-B indicated fleets be given before using the ions. NP-B stated an arses complete full bowel if there was constipation e administration of as needed	F 6	84			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED	
245153 B. WING 1	C 0/23/2020	
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684 Continued From page 38 MDS also indicated R9 received one administration of a diuretic during the assessment period. R9's Face Sheet, included diagnoses of essential hypertension, venous insufficiency, cirrhosis of the liver (scarring of the liver), chronic kidney disease stage 3(moderate kidney damage), rheumatic tricuspid insufficiency (failure of the heart's tricuspid valve to close properly), and secondary pulmonary hypertension. R9's nutrition care plan dated 9/23/2020, identified R9 was on a fluid restriction; interventions included document meal intake %, fluids, bowel movements, and urinary output as applicable each shift. Notify licensed nurse for low intake and refused meals. R9's Hospital Discharge Summary Brief Overview dated 9/21/2020, indicated R9 was hospitalized related to anemia iron deficiency blood loss. The section Active Issues Requiring Follow-Up included primary care provider to consider starting Torsemide (diuretic) at dose of 10 milligrams (mg) based on creatinine (lab) levels. R9's physician orders included: -Check heart rate, blood pressure, and Sp02 (oxygen saturations) daily (include oxygen requirement) Special instructions: Notify [name of clinic staff] if SBP (systolic blood pressure) >160 or SBP <90, HR (heart rate) >100 or <60, Sp02 <90% or increased oxygen needs, or with any other concerns (start date 9/24/2020, stop date 10/2/2020)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING	(X3	(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C 10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	COMPLETION DATE	
F 684	daily (include oxygeinstructions: Notify (systolic blood pres (heart rate) >100 or increased oxygen reconcerns. For hear if symptomatic (dizsyncope (start date 10/5/2020) No added salt diet restriction (start date 10/5/2020) Regist daily before scale. Notify provid (pounds) or <261 lb. Torsemide 10 millig daily in the morning Apply low stretch vextremities, on in the (start date 9/28/202) Regist vital sign recondentified heart rate the physician had be 9/21/2020, 11:49 a. 9/22/2020, 2:59 p.n. 9/22/2020, 6:51 p.n. 9/23/2020, 7:28 p.n. 9/24/2020, 10:26 p. 9/25/2020, 7:34 a.n. 9/26/2020, 12:25 p. 9/27/2020, 9:48 a.n. Regist 24 hour fluid in lacked documentati	en requirement) Special [name of hospital staff] if SBP (sure] > 160 or SBP < 90, HR (sec.) = 20, Sp02 < 90% or needs, or with any other trate < 60 only notify provider ziness/lightheadedness or 10/2/2020, stop date Special instructions < 1.5 fluid the 9/21/2020) the breakfast. Use the same er if weight gain > 267 lbs. tos. (start date 9/28/2020, tograms (mg) now and then by (start date 9/28/2020) the a.m. and off in the p.m. (20) the area of the providence of the sunder 60 without evidence the en notified. The matter of the providence of the p	F 6	884			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE 4001 19TH AVENUE NORTHW 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 684	revealed R9 had no days: -9/22/2020, wt. (we-9/23/2020, wt. not-9/24/2020, wt. 256-weight not taken of 9/29/209/30/2020, 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.	ight) 264.7 lbs. taken .3 lbs. n 9/25, 9/26, 9/27, 9/28, or .2 lbs. taken	F 6	84			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
	245153	B. WING				C 23/2020	
PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP O 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	CODE	10/2	20/2020	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE	
note indicated the padaily in morning and bilateral lower extreat night, ordered lal patient daily in fastithe same scale. -10/1/2020, at 1:09 diastolic pressure a symptomatic. SBAF done. A subsequent R9 had 3+ pitting extended and had increased confusion, urinary f SBAR was complet urine test. -10/4/2020, indicate and had increased called, physician direport any increased decreased intake, fitest done right now -10/5/2020, include her provider this moand needing diures send resident to emt.	chysician ordered Torsemide d apply low stretch wraps to emities, on in the morning off os for 10/1/2020, and weighing state every morning using p.m. indicated R9 had low and heart rate less than 60 and R (a communication tool) to note at 2:29 p.m. indicated dema in both legs. p.m. indicated R9 had 3+ the legs. p.m. indicated R9 had 3+ the legs. ed R9 was having increased requency and yelling out, and faxed for request for ed R9 continued to yell out confusion, physician was rected to closely monitor and ad signs of confusion, ever, and did not want a urine ed R9 was calm and slept all low up with SBAR today. d "resident had a meeting with orning. Likely in fluid overload is. Provider gave order to mergency department.	F6	584				
monitoring of fluid s	status, edema or daily weights						
	Continued From panote indicated the patient daily in fastithe same scale. -10/1/2020, at 1:09 diastolic pressure a symptomatic. SBAF done. A subsequent R9 had 3+ pitting e confusion, urinary f SBAR was completed urine test. -10/4/2020, indicated and had increased called, physician direport any increased decreased intake, f test done right now called her provider this me and needing diures send resident to em.	PROVIDER OR SUPPLIER NA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 note indicated the physician ordered Torsemide daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale. -10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. A subsequent note at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs. -10/2/2020, at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs. -10/3/2020, indicated R9 was having increased confusion, urinary frequency and yelling out, SBAR was completed and faxed for request for	PROVIDER OR SUPPLIER JA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 note indicated the physician ordered Torsemide daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale. -10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. 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R9's progress notes lacked documentation of	PROVIDER OR SUPPLIER NA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 note indicated the physician ordered Torsemide daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale. -10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. 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Likely in fluid overload and needing diuresis. Provider gave order to send resident to emergency department. R9's progress notes lacked documentation of	A BUILDING 245153 B. WING 3TREETADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MM 55901 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 note indicated the physician ordered Torsemide daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale. -10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. 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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	D. ` '		E CONSTRUCTION		E SURVEY PLETED
		245153	B. WING				C 23/2020
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC				40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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	R9's physician note revealed the following representation of hyper the patient has an target range of 261 not been weighed a weight at that time windicated her blood low, usually 90's sy diastolic. The visit in started related to hylabs were ordered, week. -10/1/2020, at 9:00 weight parameters less than 261 lb or [skilled nursing facily has been very incompave been recorded not been weighed a today and up to this documented in EMI have made 3 separ for today's weight. In nurse at Madonna included, "Patient dextremity edema, wher legs are current indicated the plan whyponatremia, order follow up next weeks.	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 spoint, 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	F6	884			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020	
	NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC			STREET ADDRESS, CITY, STATE, ZIP 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	CODE	10.20.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E E APPROPRI		
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 addrime, if nursing sign -10/6/2020 "I had a yesterday for [name symptoms. Nursing with virtual video." today. At time of visunable to answer q her need to urinate. "Per nursing staff [runwell and weak to has been confused experiencing urinar states that her eyel note indicated R9 w and did not know w note indicated the ptransfer to emerger condition. During an interview NA-C stated NA's thowever, it didn't al were busy in the me weight then the bat the weight on the red.	rking 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, as not signed on. Attempted wers, but could not reach a ent is scheduled for follow-up ress UTI symptoms at that is onto virtual visit. " Ittempted to see the patient e of person] concern of UTI 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 day, [name] states that patient for two days and has been by frequency. [Name] also ids appear to be swollen." The was alert to person and year there she was located. The ohysician gave an order to not not of the daily weights ways happen because staff orning. Stated if we miss a haide would attempt to get	F 6	884			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING _			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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH COROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	stated she did not to and it would be impropriated to alter the appropriate monitoring and assetulated balance, and setulated by status is identified by status is identified by a attending provider as a strending provider	d daily with weight. LPN-A hink it was being documented, ortant to identify a change in on 10/23/2020, at 7:42 a.m. (DON) reviewed R9's record this were not obtained per a monitoring and evaluation, was not notified when heart per the order. DON stated the identify if R9's was assessed wer heart rate. In interview on 10/29/2020, are practitioner (NP)-B, NP-B laily weights at the facility has oblem. NP-B stated residents ameters on when to notify the were also given specific and daily weights in the eakfast, using the same scale. In order for the resident to treatments nursing had to be essing for changes in weight, welling. Ocol for fluid management not received. The ge in Condition dated 2/2019, ignificant change in the mental, or psychosocial by the licensed nurse, or when the treatment significantly, the sociate consults with the	F 6	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245153	B. WING		10	C 0/ 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COD 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		72072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 688 SS=D	not specifically definin condition. A facility policy/prot was requested and Facility policy Admi included; To adminisafe and accurate rights of medication are administered in 3. Medications are prescribed time. And destroyed and document to re-attempt Facility policy Chamincluded "When a sresident's physical, status is identified by there is need to alter licensed nursing as attending provider a resident/resident renot specifically definin condition. Increase/Prevent DCFR(s): 483.25(c) (1) The firesident who enters range of motion unlocondition demonstrof motion is unavoid	ne what constitutes a change occol for bowel management not received. nistering Medications 2/2019, ster resident medications in a manner that will ensure the 6 nadministration. Medications accordance with the orders. administered within their by refused medication is umented as a refusal (did not pot). Inge in Condition dated 2/2019, significant change in the mental, or psychosocial by the licensed nurse, or when her treatment significantly, the esociate consults with the end notify the expresentative. The policy did ne what constitutes a change of the facility must ensure that a set the facility without limited the esonot experience reduction in less the resident's clinical ates that a reduction in range dable; and	F 6			12/4/20
	§483.25(c)(2) A res	ident with limited range of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245153	B. WING				23/2020
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	10/-	0.2020
MADONI	NA TOWERS OF ROC	HESTER INC			19TH AVENUE NORTHWEST HESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	motion receives appropriated services to increase prevent further decided services appropriated assistance to mainted the maximum practiced reduction in mobility unavoidable. This REQUIREMENT by: Based on interview facility failed to ensure services to meet the residents (R11, R12 restorative services. Findings include: R13 R13's face sheet prediagnoses of ataxial coordination) and desystem (loss of function system (loss of functions). R13's quarterly Minassessment dated seconditively intact, he vision, clear speech clear comprehensical assistance of one second to the component of the compon	propriate treatment and erange of motion and/or to rease in range of motion. Additional sides of motion and/or to rease in range of motion. Additional sides of motion and/or to rease in range of motion. Additional sides of independent and sides independence unless and is demonstrably. And document review, the ware staff provided restorative expressed needs for 3 of	F6	R rev R1 rev All the the 12 Au an co Ac co	2.11's care plan was reviewed and vised. 12's care plan was reviewed and vised. 13's care plan was reviewed and vised. I residents with restorative plans e potential to be affected. I restorative plans were reviewed are plans revised as necessary. I Restorative Program" policy viewed and remains current. I nursing assistants will be educate documentation of restorative ple nursing staff trainings on 12/1 and 2/2. I udits of completion of restorative ple nursing staff trainings on 12/1 and accompanying documentation of mpleted 3x/week for 4 weeks. It is distributed as a manufacture of the state of	have and was ated on ans at and plans will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING _			C / 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 688	restorative program (disease of nerves) the nervous system Goals and approach continue to ambula NuStep (stationary between 6:00 a.m. R13's point of care frequency of restoration walking. The report zero times between times, the report lis Other reasons inclusasess, deferred duand unknown. During an interview R13 stated when the was able to use the but now that they we happening. R13 stated when the was admitted she is to the small stature feel safe with them confident in the abilities of money to be here meeting my needs. brought up at reside management is mo bottom line then the was not able to tell	20, indicated R13 required to address neuromyopathy and degenerative disease of with decreased mobility. Thes indicated R13 would te 150 feet daily and use the bicycle) 10 minutes daily and 2:15 p.m. history report indicated the ative nursing related to indicated R13 ambulated 19/21/20 and 10/22/20. Three ted the reason as "refused." Inded: not observed, could not use to condition, unavailable on 10/22/20, at 12:45 p.m. They had a restorative aid, she was not attend only two staff have asked on walk in the past six weeks. Sometimes refused to walk due of some staff, as she doesn't attend only two staff have asked on walk in the past six weeks. Sometimes refused to walk due of some staff, as she doesn't attend only two staff providing is R13 stated, "I'm paying a lot e and they aren't always "R13 stated this has been ent council, "but the new are concerned about the eresidents." R13 stated she if the lack of restorative ed her, but expressed concern	F 68	the facility Quality Council nongoing frequency and dura determined through analysis of results.	ation to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC	,	40	REET ADDRESS, CITY, STATE, ZIP CODE 101 19TH AVENUE NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	R12's facesheet pri diagnoses of Parkir affecting movement debility, osteoporos brittle), muscle wear R12's quarterly Min assessment dated a cognitively intact, himpaired vision requispeech, was underscomprehension. R1 assistance of two sand toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing, locomotion on the underscompten and toileting, and reof one for dressing dated 3/24/restorative program disease with muscle approaches indicate ability to ambulate 2 for 10 minutes daily p.m. R12's point of care frequency of restorative program disease with muscle approaches indicate ability to ambulate 2 for 10 minutes daily p.m. R12's point of care frequency of restorative program disease with muscle approaches indicate a for 10 minutes daily p.m.	nted 10/23/20, indicated ason's disease (disease t), age-related physical sis (bones become weak and akness and repeated falls. simum 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	F6	888			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONS	(X3) DATE SURVEY COMPLETED			
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001 19T	ADDRESS, CITY, STATE, ZIP CODE TH AVENUE NORTHWEST STER, MN 55901	1072	25/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	During an interview R12 stated, "If they doing good, and I devery day and I'm rate. I'm not active not using the NuSte "they didn't renew they didn't renew	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 itia, age related physical tis (wearing down of bones) ess. imum Data Set (MDS) 8/11/20 indicated R11 had impairment, had adequate	F6	88			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE 4001 19TH AVENUE NORTHW ROCHESTER, MN 55901		10/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD B O THE APPROPRI	
F 688	p.m. family member doing very well. FM the time to help her everyone else and could not confirm if doubt it, but I just do "They're overwhelm don't know what's harmonic they're overwhelm don't know what's harmonic they're overwhelm don't know what's harmonic they indicated 3/25/restorative program (weakness, numbrous damage), osteoarth fibromyalgia (wide see decreased mobility indicated R11 would feet daily and use the between 6:00 a.m. R11's point of care frequency of restoration walking. The report zero times between reasons included: massess, deferred duand unknown. During an interview nursing assistant (Noworked without taking much work to get do only two aids to carhad 15 residents by stated things that destaff included: dirty walking, toileting. "I	r (FM)-E stated R11 was not I-E stated, "To get them to find I-E stated, "To get them to find I-E stated, "To get them to find I-E stated, "How 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." regory called restorative 20, indicated R11 required in to address neuromyopthay less and pain from nerve writis of both knees, and spread muscle pain) with its Goals and approaches dispersed continue to ambulate 400 the NuStep 10 minutes daily	F6	588		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		COM	E SURVEY PLETED
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, C 4001 19TH AVENUE ROCHESTER, MN		10//	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI 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 crestorative services stated, "They'll decithem." During an interview (NA)-C stated she I residents who are costated "something I NA-C acknowledge were important for ibalance and streng brought this to the a DON stated they we staff. NA-C stated to aide, but that positionursing assistants a restorative services their other responsitions.	"When asked if staff were orative services to residents as walking, NA-B stated, "I g done. We don't have the do it." When asked how lack of might affect residents, NA-B line and that's not fair to on 10/21/20, at 8:42 a.m. and not been able to walk on restorative programs and has to give; we can't do it all." at 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 ibilities.	F 6	88			
	DON stated she had assistants to complit in the electronic moving on to the new was important so the care history report a some nursing assist documenting these acknowledged the stacility and stated sinterventions, such not being done. DO	d been instructing nursing ete a task and then document nedical record (EMR) before ext task. DON explained this nat these tasks show up in the as being done. DON stated stants had been resistant to tasks in the EMR. DON staffing challenges of the he recognized that care plan as restorative serves were DN stated she did not have dent EMR's to determine if					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE 4001 19TH AVENUE NORTHV ROCHESTER, MN 55901	E, ZIP CODE	10/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 688	restorative services to the care plans. D staff about whether done, some nursing doing it, some said and some said they stated it was the exservices as indicate acknowledged there. During an interview corporate vice presstated, "in this induchallenged, we are to meet the needs of stated there was a and stated, "it's unfallowed to go." VPC meet resident need staffing and how exadding "leadership providing guidance reported they did now ho are on a restor are too busy, VPO-of some issues untial Administrator addet the facility with Covstaff quitting, and the staff some pretty go concerns were more purpose: To ensure comprehensively as restorative needs.	were being done according ON stated when she asked restorative serves were being assistants said they were they didn't have time to do it, forgot to document it. DON pectation 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 ortunate where it's been D-G stated not being able to s, was a combination of short isting staff was working, needed to be on the floor and "When informed staff of have time to walk residents rative programs because they G stated she was not aware I they rise to a certain level. If that a lot had happened at id19, changes in leadership, ying to rebuild, adding "we nod ratios" and resident care e related to staff inefficiencies. Restorative Program dated	F 6	88		

PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 0/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COI 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	-	0/23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 688	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	attain and maintain highest and psychosocial well-being. It is care promotes resident's ependence in activities g, range of motion, ambulation se will provide oversight to the the restorative interventions anted as planned.	F 6				
F 725 SS=F	CFR(s): 483.35(a)(a) Sufficie The facility must hat the appropriate corprovide nursing and resident safety and practicable physical well-being of each resident assessme care and considerind diagnoses of the factordance with that §483.70(e). §483.35(a)(1) The by sufficient number types of personnel nursing care to all resident care plans (i) Except when was this section, license (ii) Other nursing polimited to nurse aid §483.35(a)(2) Except agraph (e) of this	nt Staff. ave sufficient nursing staff with impetencies and skills sets to direlated services to assure attain or maintain the highest all, mental, and psychosocial resident, as determined by ints and individual plans of ing the number, acuity and incility's resident population in a facility assessment required facility must provide services are of each of the following on a 24-hour basis to provide residents in accordance with its inved under paragraph (e) of and nurses; and ersonnel, including but not	F 7	25		12/4/20	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION B		PLETED
		245153	B. WING		10/2	3/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	10/2	.072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	nurse on each tour This REQUIREMENT by: Based on interview facility failed to ensure and meet the asses (R11, R12, R13, R1 lack of sufficient staff had the residents who	of duty. NT is not met as evidenced and document review, the ure sufficient staff to provide sed needs for 4 of 4 residents 14) who voiced concern with affing in the facility. The lack of the potential to affect all 50	F 725	R11's care plan was reviewed and revised. R12's care plan was reviewed and revised. R13's care plan was reviewed and revised. R14's care plan was reviewed and revised. All residents who reside at Madonr Towers have the potential to be affer "Resident Rights and Notification" was reviewed and remains current "Comprehensive Assessments and Planning" policy was reviewed and remains current. "Concerns and Grievances" policy reviewed and remains current. "BHS Restorative Program" policy reviewed and remains current. Project scope worksheet has been completed for call light response tir includes the problem, the associate assigned to complete the PDCA are problem statement data based goad 4 Call system implemented by 12/4 Resident Council held on 11/19/20. All restorative plans were reviewed care plans revised as necessary. All licensed staff will be educated of Comprehensive Assessments and Planning policy at the nursing staff trainings on 12/1 and 12/2. All nursing assistants will be educated of Comprehensive Assessments will be educated to Comprehensive Assessments and Planning staff trainings on 12/1 and 12/2.	ma ected. policy I Care was was me that end I. I/2020. 20. I and on the Care	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COME	E SURVEY PLETED
		245153	B. WING		10/2	23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP C 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 725	responsible for their nursing assistants. During an interview R12 stated there we stated staff cannot her call light on and feel more helpless one comes." R12 saway because they working with." R12 on the toilet and sa aren't right back." Fare their famous we using my walker to kids say don't do the During an interview R12 stated, "If they doing good, and I devery day and I am rate. I'm not active would like to walk in the morning, she walk and staff say," R13 R13's face sheet, pdiagnoses of ataxia coordination), deget (loss of function or spinal cord). R13's quarterly Mir assessment dated cognitively intact, here	and ambulation. Staff se activities were identified as and nurses. You on 10/19/20, at 10:58 a.m. as "not enough staff." R12 always come when she puts distated, "Nothing makes you at night when it's dark and no tated, "Staff can't come right youn'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	F 72	the documentation of restor and the use of the bathing prom at the nursing staff train and 12/2. All nursing staff will be educated Resident Rights and Notificathe Concerns and Grievand BHS Restorative Program procall light system at the nursitrainings on 12/1 and 12/2. Audits of customer concernates response time will be compromed for 4 weeks. Audits of completion of rest and accompanying document completed 3x/week for 4 weeks. The facility will conduct resigninterviews and care audits, emphasis on individualized preferences 3x/week for 4 weeks. Administrator/Designee is recompliance. Results of monitoring shall the facility Quality Council rendered through analysity of results.	cated on the ation policy, ses policy, the policy and the ing staff as and call light leted 3x/week corative plnas entation will be eeks. Ident with an care and weeks. It is esponsible for the reported at meeting with ation to be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTR NG		(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001 19TH	DRESS, CITY, STATE, ZIP CODE AVENUE NORTHWEST TER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	clear comprehensic assistance of one sand toileting, locom walking in room or twice. R13's care plan goa R13 would continue daily living (ADL's) indicated R13 requibrushing teeth, growincontinence care a responsible for the snursing assistants a During an interview R13 stated in the lalost a lot of staff and stated, "I look at thr personality, efficien stated, "Most of the don't treat us with repersonable." R13 stated in the lalost a lot of staff and stated, "Most of the don't treat us with repersonable." R13 stated, "They are short staff "Management push working double shif seeing good staff le R13 stated, "Person consequences to he be answeredyet." During an interview R13 stated they use now have only one negatively impacted.	and nurses. on 10/19/20, at 2:09 p.m. st 6 months, the facility had distaff morale was low. R13 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, est hem. A lot of staff are taxe and just poor ones stay." andly, I have not suffered any aving to wait for a call light to	F 7	25			

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	bath, "she can't hel not able to get to mused to have a rest use the bicycle and they are short staffs stated the new mar concerned about th residents. R13 state to be here and they needs." R11 R11's facesheet, pr diagnosis of demendebility, osteoarthrical R11's quarterly Min assessment dated moderate cognitive hearing and vision, understood and have required extensive mobility, transfers a on and off the unit. assistance of one walking in the corrical staff occurred only R11's care plan good R11 maintain current with activities of dai plan indicated R11 compression stocking grooming, dressing and ambulation. Staff occurred only staff occurred only staff occurred staff occurred staff occurred staff occurred only sta	p me and apologizes she is a sooner." R13 stated they corative aid and was able to walk in the hall, but now that ed, she doesn't walk. R13 hagement was more be bottom line than the ed, "I'm paying a lot of money aren't always meeting my aren't always meeting my aren't always meeting my was and muscle weakness. imum Data Set (MDS) 8/11/20, indicated R11 had impairment, had adequate clear speech, was a 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			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	CODE	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 725	During an interview R11 stated she war have time." R11 stated she could not helped her walk. During a telephone p.m. family membe doing very well. FM (soiled herself) quit FM-E stated, "To go herthey're understhey don't have time call the facility to as just falls on deaf ear	ge 58 on 10/22/20, at 1:52 p.m. Inted to walk, "but staff don't Ited, "I'm losing strength." R11 of recall the last time staff Interview on 10/22/20, at 2:05 or (FM)-E stated R11 wasn't I-E stated R1 had accidents of a bit, and that upset her. of them to find the time to help taffed like everyone else and of the stated, "I've had to of the time to help toilet her and it of them to help toilet her and it of them to help toilet her and it of the stated, "They're of them to help toilet her and it of the stated, "They're of the stated, but I don't know	F 7	725			
	diagnoses of osteon bones), kyphosis (for obesity and muscle R14's quarterly Min assessment dated cognitively intact, homeonic management of the comprehension. R1 assistance of one states of the comprehension of the com	nted 10/23/20, indicated arthritis (wearing down of orward rounding of the back), weakness. imum Data Set (MDS) 10/6/20, indicated R14 was ad adequate hearing, uiring corrective lenses, clear stood and had clear 4 required extensive taff for bed mobility, transfers, ng. R14 required limited when walking in room, and of one with locomotion on the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			10/2	23/2020
	PROVIDER OR SUPPLIER	HESTER INC	,	STREET ADDRESS, CITY, STATE, 4001 19TH AVENUE NORTHWI ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 725	R14 would continued daily living (ADL's) indicated R14 requiand taking off comporal care, dressing, incontinence care a responsible for the nursing assistants a During an interview R14 stated there "a staff to meet her cahave my light on an 30 minutes." R14 stated my own that I'm not "This hallway does hasn't for most of the gone downhill terribleaving; they don't I have to do and don R14 stated when lowere brought up at heated and the adn and changed the suabout it." R14 state allowed to say much stated, "They say it but it's far from it." It between the workershow." R14 stated sfive star place but restars. During an interview nursing assistant (N	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	F7	725			

	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
	PROVIDER OR SUPPLIER	HESTER INC		4001	ET ADDRESS, CITY, STATE, ZIP CODE 19TH AVENUE NORTHWEST HESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	when the new admi work was added wirstated there used to residents, but one to NA-A stated random assist with baths on this means there are the floor to assist relights. During an interview trained medication is different lately bu and that leadership few people have left positions, adding the more than usual. To younger and the job TMA-A stated, "It's assistant, but when they bargained for.' lot of open positions right now. TMA-A stated, "prolifer to the fast when they put to the they be the they be the they be the they be the	inistrator came because more thout enough staff. NA-A to be two bath aids for 60 bath aid was taken away. In aids are now assigned to a evening and weekends and the less nursing assistants on esidents and answer call and (TMA)-A stated, "Staffing the nothing anyone can control" was trying. TMA-A stated a fit and no one was applying for the evere a lot of pool staff, MA-A stated new staff were to was not what they expected. The easy to become a nursing they get into it, it's more than they get into it, it's more than they are a stand a lot of chaos going on that they were working short that this day. When asked done due to working short, bably not get to residents very	F7	725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		400	EET ADDRESS, CITY, STATE, ZIP CODE 1 19TH AVENUE NORTHWEST CHESTER, MN 55901	1011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	to burnout and staff During an interview (RN)-A stated most RN-A stated "it see lately." RN-A stated but the nursing ass that sometimes the assistant to stay lor home. RN-A stated nursing assistants I hours, so if they we hours." RN-A stated agency staff and re available. RN-A sta nursing assistants s their work. During an interview 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 increase in incontin seen an increase ir increase of associa it was like a ticking would eventually ha to the DON, there we human resources b applicants and our DON stated they we managers, so the next	9	F 7	725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 1001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	supervisor role and "Staffing was taking is getting done." DO what they have to comproved." DON states are residents deserved. During an interview (NA)-B stated she was nable as there was NA-B stated there was left" and staff were conditions. NA-B stovertime after eight work extra, althoug stated there were or residents, stating stated that morning. NA-B gone due to lack of call lights, turning, wastated, "I've seen lights."	the DON role. DON stated, g all the focus, so nothing else DN stated, "Staff just get done to that day; nothing is being ated, "They can't provide the	F 7	725			
	(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 star attention of the DO were working on him	on 10/21/20, at 8:42 a.m. ng 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 ated she had not been able to are on restorative programs hing 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					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 10/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIF 4001 19TH AVENUE NORTHWES' ROCHESTER, MN 55901		10/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I HE APPROPR	BE COMPLÉTION	ı
F 725	position was eliminal expected to do it allower responsibilities. Not impossible to walk a substantial monetal positions and for instated they used to base, but current stated they got applicants, HR-D stated, "We gassistants who have care facility in town we are the only place a red flag." HR-D stated staffing huddle daily, they take the control of the c	ated and now all NA's are	F 7	725			

	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
	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	100	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	wages. FM-C stated putting individuals to course, paying for to full time position. During an interview corporate vice presstated, "In this induchallenged, we are to meet the needs of stated there was a and "It's unfortunate go." VPO-G stated resident needs was staffing and how existating "leadership providing guidance that a lot had happe Covid19, changes if and trying to rebuild "We staff some precare concerns were inefficiencies. Facility policy titled Assignments dated Purpose: to ensure accordance with respolicy: Sufficient nuand competency needs assignment and competency needs assignment and competency needs assignment and accordance with propractice.	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 where it's been allowed to not being able to meet a combination of short disting staff were working, needed to be on the floor and at the facility with a leadership, staff quitting, d. The administrator stated, the good ratios" and resident at more related to staff Staffing and Daily Work 2018, indicated: staff provide cares in	F 7	725			
	Assignments dated Purpose: to ensure accordance with responding sufficient nuand competency neservices for all resident care plans All nursing service work assignment as accordance with propractice. Procedure:	2018, indicated: staff provide cares in sident needs. umbers 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					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	1 10/	2012020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 755 SS=D	of direct care staff a of the residents bas care. 2. Inquires and conshould be directed 3. Certified nursing trainees carry out the profession manner established nursing. Facility Assessment 1. Person-centered based upon needs included Quality of assistance, bowel a support, and rehab 2. Staffing is plan based upon census addition, staffing in upon resident need and discharges. Pharmacy Srvcs/Procedures/FCFR(s): 483.45(a)(§483.45 Pharmacy The facility must profuge and biological them under an agres §483.70(g). The facility must profuge and biological them under an agres §483.70(g). The facility must profuge and biological them under an agres §483.70(g). The facility must profuge and biological them under an agres §483.45(a) Proceding permits, but only una licensed nurse.	are determined by the needs sked on each residents plan of oncerns relative to staffing to the administrator/designee. It is a sasistants (CNAs) and heir daily assignment in a and in accordance with grocedures and protocols. It, 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. In all departments. In nursing are altered based and the number of admission Pharmacist/Records b)(1)-(3)	F 7			12/4/20	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245153	B. WING			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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE	LD BE	(X5) COMPLETION DATE
F 755	§483.45(b) Service must employ or obto pharmacist who- §483.45(b)(1) Provous aspects of the provous the facility. §483.45(b)(2) Estain receipt and disposition sufficient detail to expression or expression of the provous facility failed to ensore a variable for a corders for 2 of 3 restormedication error for the provous facility failed to ensore a variable for a corders for 2 of 3 restormedication error for the provous facility failed to ensore a variable for a corders for 2 of 3 restormedication error for the provous facility failed to ensore for 2 of 3 restormedication error for the provous facility failed to ensore a variable for a corders for 2 of 3 restormedication error for the provous failure, alcoholic cirous failure, alcoholic c	the needs of each resident. Consultation. The facility rain the services of a licensed dides consultation on all ision of pharmacy services in ablishes a system of records of tion of all controlled drugs in the rable an accurate did and periodically reconciled. The shade of the resident's medications administration per physician sidents (R1 and R9) reviewed residents of liver, diabetes type to behavioral disturbance, and elimination care plan dated is taking lactulose; goal of 2-3 per day due to cirrhosis.	F7	R1's lactulose order was edited indication for use hepatic failure 10/23/20 and order remains active R9 is no longer in the facility. All residents who reside at Mado Towers have the potential to be a "Administering Medications" poli reviewed and remains current. Alixa Pharmacy "Unavailable Medications" policy was reviewer remains current. All licensed staff and TMAs will be educated on Administering Mediand Unavailable Medications po 12/1 and 12/2.	on /e. onna affected. cy was d and oe cations	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		E SURVEY PLETED
		245153	B. WING			C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COD 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION 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 digiven related to the -8/4/2020, MAR - or drug/item unavailable -8/5/2020, MAR - 2 administered: drug/-8/30/2020, MAR - 2 administered: drug/-8/30/2020, MAR - drug/item unavailable -9/15/2020, MAR - drug/item unavailable -9/27/2020, MAR - drug/item unavailable -9/27/2020, MAR - administered: drug/-8/22/2020, MAR - administered: drug/-8/22/2020, MAR - administered: drug/-8/22/2020, MAR - 2 administered: drug/-8/23/2020, included hypertension, venothe liver, Chronic ki	late 8/19/2020). milligrams (mg); administer 1-2 a day (start date 8/19/2020) androitin 500-400 mg twice a 1/2020). ministration record (MAR) oses of lactulose were not medication not available. The dose was not administered: ole. The doses were not item unavailable. The doses were not item unavailable. The doses not administered; ole. The doses were not item unavailable and oitin the doses were not item unavailable. The doses were not item unavailable and oitin the doses of essential us insufficiency, cirrhosis of doses disease stage 3, insufficiency, and secondary	F 75	Audits of Electronic Medication Administration system "Admin Compliance Report" for medicavailable/no given will be com 3x/week for 4 weeks. Administrator/Designee is rescompliance. Results of monitoring shall be the facility Quality Council medongoing frequency and duratic determined through analysis of results.	nistration not appleted sponsible for e reported at seting with on to be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING			1	
NAME OF F	PROVIDER OR SUPPLIER	243133	D. WIING		REET ADDRESS, CITY, STATE, ZIP CODE	10/2	23/2020
					01 19TH AVENUE NORTHWEST		
MADON	IA TOWERS OF ROC	HESTER INC		R	OCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO		BE	(X5) COMPLETION DATE
F 755	R9's physician order-Amitriptyline 2%-kelipoderm cream, aptopically two times -Nystatin powder 1 application four times 9/21/2020) -Hydrocortisone crecketoconazole and atwice a day (start displayed) 10/3/2020) R9's medication adidentified the medical not available to address medication administation administ	ers included: etamine 5% -lidocaine 2% in a ply 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 ministration record (MAR) cated cream/ointments were minister per physician orders. stration record (MAR) on cion was not administered; alternation of 4 application not macy won't send and ale. of 4 applications not fitem unavailable. of 4 application not fitem unavailable. of 4 applications not fitem unavailable.	F 7	755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	()		CON	COMPLETED	
		245153	B. WING _			C / 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COE 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	administered; drug, MAR 9/27/2020, 1 administered; drug, MAR 9/30/2020, 1 administered; drug, MAR 10/2/2020, 1 administered; drug, MAR 10/2/2020, 1 administered; drug, During an interview trained medication was not to let the nurse know are supposed to or unawareness if it werror if the medication error reference of nursing were not available considered a medication error recompleted, the phy notified, and the phy notified, and the phy notified, and the phy notified are dications were two was a medication rijust give when the confirmed pharmacy available 24/7, how to communicate the immediately. PT standard the medication were the medication were the medication or the phy notified and the phy notified are medications were the medication were the medication or the phy notified and the phy notified, and the phy notified and the phy notified are physically and the physical ph	of 2 applications not ditem unavailable. of 2 applications not ditem unavailable of 2 applications not ditem unavailable. On 10/19/2020, at 9:37 a.m. assistant (TMA)-B stated if a tavailable then then supposed w; if it's not ordered then we der it. TMA-B indicated an eas considered a medication ion was not available from the considered of the medications for administration, it was cation error. The DON stated a port should have been sician should have been	F 7	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001 1	TADDRESS, CITY, STATE, ZIP CODE 19TH AVENUE NORTHWEST HESTER, MN 55901	1 10/1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	considered medicar During an interview licensed practical in medication was not medication error an notified. LPN-A indicontacted. LPN-A idid not have the medication the back-up pharmator of the back-up pharmator of the notified. DON stated if a medication the notified. DON stated if a medication of the notified. DON stated if a medicated of the notified of the notified. Don's the notified of t	on 10/22/2020, at 9:34 a.m. urse (LPN)-A stated if a available it was considered and the nurse should be cated the pharmacy should be tated if the primary pharmacy edication then we would call	F 7	55			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245153	B. WING _			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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760 SS=J	CFR(s): 483.45(f)(2) The facility must en §483.45(f)(2) Reside medication errors. This REQUIREMENT by: Based on observative review, the facility for residents (R1 and for management were care in accordance practice. This praction in administration of the properties of the properties of the properties of the properties of the IJ on 10/21/2 removed on 10/22/2 non-compliance reseverity level of G, is not immediate jeen addition, the facility administer per physical properties indication administer per physical properties in the properties of the IJ on 10/21/2 removed on 10/22/2 non-compliance reseverity level of G, is not immediate jeen In addition, the facility administer per physical properties (R1) review Findings include:	sure that its- ents are free of any significant NT 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 visituation for R1. pardy 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 mained at a lower scope and a pattern with actual harm but opardy.	F 70	R1's orders have been reviewed regularly reviewed by providers a diabetic order set with monitoring added. R4's orders have been reviewed regularly reviewed by providers a diabetic order set with monitoring added. All residents residing at Madonna have the potential to be affected. "Change in Condition" policy revie and remains current. "Administering Medications" policy reviewed and remains current. "Medication Error/Occurrence" poreviewed and remains current. Licensed nursing staff, as part of abatement plan were reeducated facility's insulin administration prowith emphasis on blood sugar monand meal intake. Meal intake has added for diabetic residents and rorders to monitor for hyper/hypog and emergency protocols. Licensed nursing staff, as part of abatement plan were educated or signs/symptoms of hypoglycemia as hyperglycemia. Licensed nursing staff will be edu	and the was and are nd the was a Towers ewed y blicy the on the stocol onitoring been nursing llycemia the n as well	12/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 t. BOILB			(
		245153	B. WING			10/2	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 OCHESTER, MN 55901		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	diabetes, hepatic [li of the liver and den disturbance. R1's admission Mir assessment dated severe cognitive im with eating, and red 8/24/20, indicated, physical assist and R1's diabetic care pindicated R1 had ty insulin. R1 goals ir complications r/t [reglucose will remain parameters". Correincluded, administed ordered, monitor blobserve for any sighypo/hyperglycemiceading). R1's nutri 10/19/20, directed fand indicated R1's and required cuing (10/19/20). During observation was observed to sit wheelchair with tray Oreo cookies taker diabetic and often tand he did not thinklow. R1 was not ab already received hi	ver] failure, alcoholic cirrhosis nentia without behavioral simum Data Set (MDS) 8/7/20, indicated R1 had pairment, was independent quired insulin. MDS dated R1 required one person supervision for eating. clan revised on 8/27/20, pe 1 diabetes that required neluded, "Will have no elated to] diabetes and blood within prescribed sponding interventions ared diabetes medications as good glucose as ordered, and ns/symptoms of a (low/high blood sugar tion care plan revised on to 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 y table in front of him, with a part. R1 stated he was a imes his blood sugar was low, as he could tell when he was le to articulate if he had is insulin before the evening that articulate if he usually	F 7	760	the facility's insulin administration pand signs/symptoms of hypo/hyperglycemia at the nursing trainings on 12/1 and 12/2. Licensed nursing staff will be educated the Change in Condition, Administed Medications, which includes indicated use and the Medication error/Occupolicies at the nursing staff training 12/1 and 12/2. Audits of blood sugar values and in administration records will be composited for 4 weeks. Symptom recognition and insulin administration audits will be completed 5x/week doe 4 weeks with EMR refunction - "Facility Activity Report" a "Administration Compliance". Audits of medication orders for indifer use will be completed 5x/week weeks. Administrator/Designee is responsicompliance. Results of monitoring shall be reported facility Quality Council meeting ongoing frequency and duration to determined through analysis and reforesults.	staff ated on ering tion for rrence s on asulin olleted eted porting and cation for 4 ble for rted at with be	

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	R1's current physic -Fragile diabetic. M a.m. Provide snack 9/14/20) -Blood sugar check a.m., 11:00 a.m. 4:0 date 8/4/20, stop dacurrentOffer assistance w to current) Novolog aspart u-1 hold insulin aspart i -Novolog aspart slic sugars above 200 r 8:00, 12:00 p.m. an 8/19/20) -Lantus U-100 pen; morning and 12 uni Facility Standing Ho Management dated diabetic management dated	ian orders included: onitor blood glucose at 2:00 as needed (start date s four times a day at 6:00 00 p.m. and 8:00 p.m. (start ate 8/5/20)- then 8/19/20 to ith meals (start date 8/23/20, 00; administer 12, 6, and 7, f not eating (start date 9/2/20) ding correction scale for blood mg/dl, three times a day at id 5:00 p.m. (start date administer 24 units in the ts at bed time (start date 8/19) buse Orders for Symptom 13/20, included orders for	F7	760	DETIGIENT)		
	administer glucagor (intramuscularly). R <70 and patient still contrary to advance	n 1 mg (milligram) IM Repeat BG after 10 minutes; if I unresponsive, unless e care plan-call 911 and notify ly. If BG remains <70 but					

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		245153	B. WING _			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 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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 760	conscious patient. Or recheck BG after 60 occurrence of any hyprovider the next but R1's hospital After vincluded "Monitor by bed time and 0200 hypoglycemia.) Blomg/dl (milligrams prograd due to advance A review of R1's bloconjunction with R1 record (MAR), nurs were reviewed from identified blood sugrecord did not alwa interventions when addition, R1's record signs/symptoms of record included docadministration" of ir and failed to demorn otified per physicial standing orders. Progress notes on 76 mg/dl, the MAR record) indicated "lagave OJ (orange justice of the progress note date indicated R1 was a and supper, physic resulted in an order	s, initiate interventions for the Once patient is stable, on minutes. Communicate hypoglycemic event to usiness day. Visit Summary dated 8/4/20, lood glucose 5 times daily, [2:00 a.m.] (To monitor for od glucose goal is 120-180 er deciliter) higher glucose ed age." Tood sugar record in 's medication administration ing notes and assessments a 8/1 to 10/19/20. R1's record ars below 80 mg/dl. R1's ys include a reassessment of readings were low. In d lacked monitoring for hypoglycemia. Further, R1's cumentation of "late is ulin and blood sugar checks, astrate 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 76	60			

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		245153	B. WING				2 3/2020
	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST COCHESTER, MN 55901	1 10/2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	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 phys indicated physician gave new orders fo referenced blood su 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 recor and at 9:45 p.m. wa the progress note ir completed 30 minum 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 1	nitoring per physician orders. BG was 112 mg/dl, and hits was administered. At 5:35 are glucagon (injection to bood sugars) per order and sponding progress note at "Resident BS checked at 33." The note indicated PRN nistered, R1 was lethargic, with dinner, and checked BS the meal it went up to 72, and 291. The record indicated the ed. sician visit dated 8/7/20, reviewed blood sugars and rinsulin. The note also agar goal range of 120-180 b.m. BG was 68 mg/dl. offered rogress note identified the BS nutes later however the BG hisistent with the progress rd read 452 mg/dl at 8:16 p.m. as 430 mg/dl. Furthermore, andicated the recheck was tes later rather than 15 and did not include signs and plycemia.	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245153	B. WING _			C / 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	blood sugars was of mg/dl, and 70 mg mote at 8:29 p.m. in glucose at 1600 [4: recorded time on B vitals were stable. I positive shakiness, drowsy. Standing of After 15 minutes rewas closely monito again and it was 70 conscious. On call give additional glucoswallow." The note orange juice with smeal. After 30 minut 116 mg/dl. At 8:00 On 8/12/20, BS at meal intake was re 8 units of Aspart was BS was 61 mg/dl. Oat 8:06 p.m. include [inconsistent with recorded to a single fluid. 2 ensure supple 125. Resident regander indicated R1 with the shift. The note did rechecked. On 8/13/20, at 3:10 intake was not recorded symptoms of heads at 10 minutes.	rt 10 units. At 5:35 p.m. R1's documented as 27 mg/dl, 140 mg/dl. Corresponding progress acluded "Resident blood 00 p.m inconsistent with G log] was 27 mg/dl other Resident was symptomatic, sweating, confused, and order glucagon 1 mg IM given. Schecked, 140 mg/dl. Resident red, after 30 minutes checked mg/dl resident was doctor updated and order to agon if resident is unable to indicated R1 was offered upper, and consumed 75% of ates rechecked and BS was p.m. BS was 251 mg/dl. 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]. It and was able to swallow olements given. BS recheck @ ined his consciousness." The was responsive the rest of the not identify when BS was	F 76			

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		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST OCHESTER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	indicated physician made adjustments sugars in the morni 200-300. R1's MAR indicated scheduled oral hydrogen administered: "wou on 8/15/20, R1's madinner intake was moreogress note at 1:5 encouragement and was checked at 12: MAR indicated Asplate at 1:48 p.m. Threcheck prior to the 4:54 p.m. BS was 237 mg/dl, at 4:57 p. 5:15 p.m. BS was 237 mg/dl, at 4:57 p. 5:15 p.m. BS was 237 mg/dl, at 4:57 p. 5:15 p.m. [time is incons BS record] to check prior to the check prior to the check prior to the distribution of the check prior to the distribution of the p.m. [time is incons BS record] to check president was unconsight away and block and other vitals were glucagon IM as standing glucose was 41 mg p.m. and paramedic p.m. Prior to arrival starting to make mostill weak. Resident	reviewed blood sugars and to insulin based on high blood ng and bedtime reading of and bedtime was not all not wake up for meds". To a mindicated R1 required a mindicated mindicated mindicated mindicated mindicated and second did not identify a BS administration of insulin. At mindicated m	F7	760			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, COV	E SURVEY MPLETED
		245153	B. WING			C / 23/2020
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F 760	8/15/20, presented "unconscious due to setting of medication found on 8/15 with received 2 doses of with minimal improvements administered 50% glucose) with to 120. BG on arrivous report, patient has hypoglycemia lately stable and shivering regards to the patienthe collateral history doctor] in Endocrined did not eat lunch but additionally, he had hydrocortisone. Both have precipitated how have precipitated how have precipitated how his insulin regimbetter control of hype R1's telehealth phy referenced R1's carevent on 8/15/20. To sleepy in the morning hydrocortisone, and also a strong patter meal when his wife his meals when his adjustments were resulted.	Visit Summary (AVS) dated to the emergency room o severe hypoglycemia in the on misadministration. "He was a blood glucose of 20. He f glucagon prior to EMS arrival wement (up to 40 then 50). ½ amp of D50 (an ampule of improvement of blood glucose al to ED was 116. Per EMS had repeated episodes of y. He was hemodynamically g on arrival to the EDIn ent's episode of hypoglycemia, y collected by [name of cology reveals that the patient at he was still given insulin. It skipped his morning the of these incidents could is hypoglycemic episode." The R1's hypoglycemic episode. "The R1's hypoglycemia resolved men was adjusted to help with coglycemia. The sician visit note dated 8/20/20, usal factors of hypoglycemic in hote indicated R1 was ng, difficult to administer d "while inpatient, there was in of him completing 100% of was present and only 25% of wife was not there." No	F 7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	СОМ	(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C 23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	100		
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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 administere identified Aspart 9 discheduled before da.m. BS was 54 mg asymptomatic, app pudding, and peans provided. Correspo "Resident's blood s [inconsistent with remg/dl. He was alert snack provided." The sugar was not check the snack provided. The sugar was not check the snack provided. The sugar was not check the snack provided of the snack provided of the snack provided of the snack provided. The sugar was not check the snack provided of the snack provided o	re have reliable oral intake. Ilin if not eating." 5 p.m. BS was 195 mg/dl, meal of different intake amounts for different intake amounts was administered as inner. On 8/27/20, at 1:16 g/dl. MAR indicated R1 was de juice with sugar, vanilla ut butter crackers were unding progress note included ugar at 12:50 a.m. ecorded BS record] was 54 and talking. HS [bedtime] he note indicated R1's blood exed 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. a.m. BS was 65 mg/dl, MAR as not administered. Record so, recheck, and monitoring for	F 76				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
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F 760	83. Gave milk and recheck BS after. V signs of hypoglycer R1's physician telel referenced low BS 9/6. Note further income made to insulin The note directed for administering insulicontinue to monitor NP/PA/MD if BS <8 weekly." On 9/15/20, at 7:02 indicated insulin was administered peant juice with sugar. Princluded, "BG at 06 with 3 sugar packed The note also indicunch was 436 mg/stat R1's blood sugwas monitored follows m	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 60. Review blood sugars 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. 600 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 ar was retaken and that R1 owing the interventions.	F 70	60				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C / 23/2020
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F 760	and R1 was admini 12:07 p.m. was 52 and at 1:55 p.m. was 1:56 p.m. indicated inconsistent with blooms in the consistent with blooms in the consistent was seminensure given prior of the constant was assisting Recheck BG 144 properties. When the consistent was administered and documented late at what time the insuli p.m. BS was 64 mg held. Corresponding Included "Resident" mg/dl. Asymptomatic check BG after 15 mevidence of snack in rechecked. R1's record lacked notified of blood sugmented intake record time snack. On 10/12/20, at 7:2 meal intake record time snack. On 10/12/20 was 68 mg/dl. R1's interventions, and resymptoms of hypograms of hypograms. On 10/14/20, at 4:1	stered 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." :00 p.m. was 273, meal intake ify R1's intake for dinner, R1 aspart 11 units and was 8:07 p.m., it's not evident n was administered. At 7:36 g/dl and Lantus insulin was g progress note at 8:06 p.m. is BG at evening was 64 ic. Offered snacks and will minutes. The record lacked ntake, or R1's BS was evidence the physician was gar below 80. 3 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.	F 7	60		

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(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	indicated R1 ate 1-2 progress notes indicated R1 ate 1-2 progress notes indicated not eat well, ins lacked evidence of monitoring for sings R1's record lacked notified of blood sugary. On 10/16/20, at 10: intake record did not meal. MAR indicate Aspart 6 units. At 4 4:44 p.m. BS as 88 Corresponding progincluded "Res BS a snacks and resident went up to 88. BS 1 did receive snack". rechecks according signs/symptoms of R1's record lacked notified of blood sugary. During an interview the director of nursidid not have individed house glucometer of unawareness of R1 stated an analysis of completed to ascert the hypoglycemic enhaving discussion of the R1's hypoglycemic enhaver enhanced	25% of food. Corresponding cated R1 ate <50% of dinner, ulin 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 nooned R1 was administered at 5 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 that 25% of his meal. BS 80 at HS [bed time], resident Record lacked evidence of to order and monitoring of hyperglycemia.	F 7	60			

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	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	1011	20,2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 760	R1's record and very between the admin 911 was called. The are supposed to be meals, and up to 30 insulin administratic and insulin administration at the time of admir low there should be 15 minutes until saft hypoglycemia/hype notification per order information was supprogress note During an interview registered nurse (R blood sugar at 10:4 mg/dl, she did not a when he got his luntray would be delivered indicated R1's blood even though it was insulin would be addicated practical in sugars are taken was part was suppose meal, and if BS low interventions and results and if BS low interventions and results are administered short.	rified there was a time gap istration of insulin and time e DON stated blood sugars e checked half hour before 0 minutes prior to aspart on. She stated blood sugars tration needed to be entered histration, and if blood sugar is e rechecks completed every fe range, monitoring for erglycemia, with physician ers. The DON stated all phosed to be documented in a con 10/20/20, at 11:39 a.m. exp. a.m., blood sugar was 197 administer insulin, and would not 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 ministered. From 10/20/20, at 4:00 p.m. every con 10/20/20, at 4:00 p.m. every construction of the province of the pro	F 76					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST OCHESTER, MN 55901	107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	stated R16's blood p.m. was 199, RN-E units was administed tray delivery. During an interview NA-C stated meal in recorded because of with meals and collowould put the tray in eat by himself but of with eating, R1 woustated R1 had low a he was low he acts NA-C stated R1's before meals. During an interview NA-F stated meal in documented but did NA's were aware of they had to wait to get they had their blood residents got their in low the nurse would resident to eat. During an interview licensed practical in acting insulin should minutes before the blood sugar was on meal, then the insul should be evaluated eating.	ge 84 sugar was at around 3:30 E administered R16's aspart 6 ered at 4:50 p.m. with meal on 10/22/20, at 9:23 a.m. htakes didn't always get different staff are assisting ecting trays. NA-C stated staff in front of R1 to see if he would otherwise required assistance and high blood sugars, when different, he would fall asleep. lood sugar would be taken over, unaware of how long on 10/22/20, at 9:56 a.m. htake was supposed to be dn't always do it. NA-F stated of who were diabetics because give residents trays until after of sugar checked and the hsulin. If the blood sugar is of tell us what to give the on 10/22/20, at 9:34 a.m. urse (LPN)-A stated rapid of be administered 15-30 meal. LPN-A indicated if of the lower side before the lin dose and blood sugar of, and held if resident not on 10/29/20, the nurse	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245153	B. WING		10	C 0/23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COD 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		720,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD 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 be 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 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 a facility, such as meal thought that R1's a result of not finishing his equired assistance, however and not been reported by facility indicated if the blood sugar ose to meal times and insulinguased off the blood sugar and much time had elapsed and atte, could cause B stated aspart insulin should a before 15 minutes prior to a semeal. NP-B indicated additionally after administered. If the timing of the insulingual accurately, it make adjustments to insuling a parameters for notifications resident, staff should be ian per order or per the P-B stated physician's orders and the followed; rechecks the suntil normal, in addition to the grant per of the interventions are stated an expectation that completed of the interventions	F7	60			

PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 23/2020	
	PROVIDER OR SUPPLIER			S 4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	10/2	23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 760	conducted by the p with updates to R1' addition all licensed re-educated on the protocol with an en monitoring, and me on signs and symp Finally, the facility of an auditing system compliance. R4 INSULIN R4's annual Minima 8/3/20, indicated R impairment and wa The MDS also indic R4's care plan date diagnosis of diabet sugars. The interve glucose as ordered importance of not s monitor/document/ hyper/hypoglycemi R4 submitted a grie The grievance inclu coffee area when [I said "I still haven't g insulin was given to states staff told her [Staff name] didn't get resident breakf following up include received her menu	's blood sugars was rovider again on 10/22/20, is plan of care made. In id nursing staff were facility's insulin administration aphasis on blood sugar real intake as well as education toms of hypo/hyperglycemia. Ideveloped and implemented to ensure ongoing um Data Set (MDS) dated in developed and implemented to ensure ongoing um Data Set (MDS) dated in developed and implemented in ensure ongoing um Data Set (MDS) dated in developed and implemented in ensure ongoing um Data Set (MDS) dated in ensure ongoing in dependent with eating. The ensure of eated R4 required insulin.	F 7	760				

	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
	PROVIDER OR SUPPLIER	HESTER INC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	1 10/2	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	food." Actions: re-e med error report. During an interview R4 sat in her room nurses don't adminiwith meals. R4 stati 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 iden 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 order Novolog Flex Pen Administer 3 units whoon, and 7 units a EATING, or BG <10 the end of each me reduced if she can to ask staff to reduce Novolog based on a should not be allow	ducated nurse and completed r, on 10/20/20, at 12:17 a.m. in her wheel chair. R4 stated ister her insulin the right way; ed she had filed a grievance but couldn't remember the waited over an hour for her she was administered insulin, she didn't get her breakfast. noon insulin was also a e, and in the middle of the ar was in the 50's. R4 stated ing staff how to administer atment Incident Report dated tify the administration of kfast 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 be administered with or just re-educated."		760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		()	(X3) DATE SURVEY COMPLETED		
		245153	B. WING			C 10/23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	DDE	10/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD B	
F 760	9/28/20Tresiba FlexTouch administer 21 units 8/5/20, stop date 10-Insulin aspart; amo scale; if blood sugar 251 to 350- give 2 units, if greater than 500, call the physic meals correction as Below 80: subtract 80-100 subtract 1 ugive only meal dose R4's blood sugar rerecord identified on 7:35 a.m. R4's recordidentified on 7:35 a.m. recordidentified the morni long-acting insulinus ugar in adults) 21 3 units was administered the dose given after 9:00 a.m. not had her breakfaidentified the lunch administered late a the 5:00 p.m. dose	Pen U-100 (insulin degludec) every morning (start date 0/16/20) bunt to administer; per sliding r is 200 to 250- give 1 unit, if units, If 351 to 400-give 3 a 400- give 4 units, and if over ian. Provide correct post is follows three times a day: 2 units from meal dose. 101-200 e (start date 3/4/20). Becord was reviewed; the 9/9/20, at 7:32 a.m. and at orded blood sugar was 193. Fig. p.m. recorded BS was 113 ap.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 is tered on time; the MAR did is ses were administered late or in., when R4 reported she had last. R4's MAR on 9/9/20, dose of Aspart 5 units was ta:43 p.m. The MAR identified of aspart 5 units was ta:40 p.m. plus aspart 3 units	F 7	760		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST OCHESTER, MN 55901	1 10/2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	A Hypoglycemia Ev 3:37 a.m. indicated was 50, "insulin asp p.m. and 8 units giv units given at 7:35 a confusion/mental la impaired speech, or included; glucagon juice; the intervention R4's record lacked medication errors a hypoglycemia as a R4's progress note included, "Resident at approx. 0205. Shoused and wasn't rouched. Skin was a mg IM injection retrigiven in left deltoid. sugar was 69 mg/dl arouse. At 0233 shouse able to chew a gluc with 2 added sugar sugar was 113 mg/d 197 mg/dL. I was alwith her and she stated that R4 had not got administration, the stated that R4 had not got administration, the	ent Report dated 9/10/20, at R4's blood sugar at 2:05 a.m. part 5 units given late at 3:35 yen at 6:20 p.m. Tresiba 21 a.m." with symptoms of pse, weakness/fatigue, old and clammy. Interventions injection, glucose tab, fruit ons were effective. identification of the insulin and/or evidence monitoring for result of late administrations. dated 9/10/20, at 3:33 a.m., 's blood sugar was 50 mg/dL are was lethargic with eyes esponding when spoke to or clammy to touch. Glucagon 1 dieved from e-kit and was at 0220. At 0225 her blood L and was still difficult to be started to wake up and was ose tablet and drink some OJ packets. At 0240 her blood dL. At 0300 blood sugar was ble to have a conversation	F 7	760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		400	EET ADDRESS, CITY, STATE, ZIP CODE 1 19TH AVENUE NORTHWEST CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	director of nursing (given insulin after hemodication error repulses was provided nurse who made the her position after sheducation on proper R1 LACTULOSE R1's Face Sheet infailure, alcoholic cirely, dementia without constipation. R1's After Visit Sumindicated while R1 was Ammonia levels we for concern of hepaimproved during the continue lactulose as summary indicated candidate at this time order "lactulose 10 solution, take 30 ml Goal is for 2-3 BM [R1's elimination car is taking lactulose; per day due to cirrhe R1's physician order (start date 8/19/20)	on 10/20/20, at 11:16 a.m. (DON) confirmed R4 had been er meals. DON indicated a port was filled out, and the education. DON stated the emedication error, resigned newas provided with r insulin administration. Cluded diagnoses of hepatic rhosis of liver, diabetes type to behavioral disturbance, and amary (AVS) dated 8/4/20, was hospitalized blood are 89, "Lactulose was started tic encephalopathy. Cognition encephalopathy. Cognition encephalopathy. The discharge R1 was not a transplant ne. The AVS included the gram/15 milliliters (mI) by mouth three times a day. Bowel movements per day. The plan dated 8/4/20, included goal of 2-3 bowel movements osis.	F 7	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245153	B. WING				C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, 4001 19TH AVENUE ROCHESTER, M		, 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	multiple doses of lato the medication in stools. The MAR with R1's bowel more records identified in were not given relatinappropriately held goal of 2-3 bowel in resident refusals with and physician notified 8/4/20, MAR- one of drug/item unavailable 8/5/20, MAR- 3 of administered: drug/(no bowel moveme 8/6/20, MAR - 2 of administered: drug/(no bowel moveme 8/6/20, BMR, nor On 8/8/20, BMR; nor On 8/8/20, BMR; nor On 8/8/20, BMR; nor B/10/20, MAR - 1 or administered: Held 8/12/20, BMR; nor administered: Held 8/12/20, BMR; nor administered: on homedium and large R1's physician visit "Patient also has his encephalopathy. His given 3 times da bowel movements."	actulose were not given related of available or held for loose as reviewed in conjunction overment record (BMR); the nultiple doses of lactulose ted to medication unavailable, d for loose stools, not meeting novements per day and/or ithout evidence of re-attempts ication. dose was not administered; ole. 3 doses were not (item unavailable. BMR: none ints) 3 doses were not (item unavailable. BMR: one interest of a doses were not if a doses was not if a dose	F 7	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		20/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE AP	LD BE	(X5) COMPLETION DATE	
F 760		nge 92 on a regular basis and is nen the patient has a loose	F 7	60			
	any documentation 8/21/20, MAR - 1 of administered: due to bm. 8/22/20, BMR- one 8/23/20, MAR -1 of	18/20, BMR did not identify f 3 doses was not co condition. BMR; one large large bm 3 doses was not old loose bm. BMR; none					
	the recapitulation fr directed to continue having 2-3 bowel m also included, "Lac on a couple of occa Writing orders toda	note dated 8/24/20, included from the hospital visit that the the lactulose with a goal of novements per day. The note tulose doses have been held asions on review of the MAR. By to administer to aim to movements per day.					
	due to condition. BI 8/27/20, BMR - nor bm. 8/29/20, MAR - 1 o due to condition. BI 8/30/20, MAR - 2 o drug/item unavailab 9/13/20, MAR - 1 o On hold for loose s 9/14/20, BMR; one 9/15/20, MAR - 1 o drug item unavailab	ne, 8/28/20, BMR; one small f 3 doses not administered: MR; none f 3 doses not administered; ole. f 3 doses not administered; tools. BMR; one large soft bm. medium soft formed bm f 3 doses not administered;					

	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
	PROVIDER OR SUPPLIER	HESTER INC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 001 19TH AVENUE NORTHWEST COCHESTER, MN 55901	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 760	drug item unavailab movement. 10/14/20, MAR- 1 or resident refused. Bl. 10/17/20, MAR- 1 or resident refused. Bl. 10/17/20, MAR- 1 or resident refused. Bl. R1's record and fact and found medication for the omitted Lact the physician had b. During an interview pharmacy technicial were delivered to the medication not avail when the medication pharmacy delivery showever facility statistically wanted the medication, facility physician; omission considered medication. During an interview pharmacist (PH) statistically statistically physician; omission considered medication, facility physician; omission considered medication, facility indicated when some body accumulates a isn't administered a bowel movements it to rise and cause furnild symptoms would elirium, and more	of 3 doses not administered; MR; none of 3 doses not administered; MR; one medium soft formed of 3 doses not administered; MR; one medium soft formed of 3 doses not administered; MR; no documentation. Solity information was reviewed on errors were not completed ulose, and lacked evidence een notified. on 10/21/20, at 2:35 p.m. the in (PT) stated medications are facility, if there was a lable then staff would just give on was available. PT confirmed services were available 24/7, if would have to communicate edication immediately. PT acy did not have the staff should notify the of medication was	F 7	760			

AND DIAN OF CORRECTION \ IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED		
		245153	B. WING _			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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760	registered nurse (R received lactulose, constipation". RN-0 orders and confirme with the medication hepatic encephalophis job to ensure the medications. RN standed for loose stools based on the wrong. During an interview licensed practical nedication was not considered a medication was needed to communicated medications there was an evaluated medications. During an interview director of nursing (not available the proposition of the medication was needed to communicate the medications. During an interview director of nursing (not available the proposition of the medicate of the indicate of the indic	on 10/21/20, at 3:02 p.m. N)-C was asked why R1 RN responded "for C reviewed R1's medication ed the diagnoses associated was "constipation" and not eathy. RN-C stated it was not e correct indications for ated the medication had been s and shouldn't have been	F 76	60		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245153	B. WING			C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	1 10/	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 761 SS=D	included; To admin safe and accurate in rights of medications. Medications are additional the orders. Medications are additional medications are additional medication will conquestions or conces of the orders. The person preparation medication will conquestions or conces of the order of the	nistering Medications 2/2019, ister resident medications in a manner that will ensure the 6 nadministration. ministered in accordance with ministered within their or administering the tact the provider if there are regarding medication. The administering the state of the electronic record/MAR on administering the state of the electronic record/MAR on administration. The electronic record/MAR on administration. The electronic record/MAR on administration. The electronic record/MAR on administration administration and efusal (did not instruct to cation error is noted refer to colicy. and Biologicals h)(1)(2) The good of Drugs and Biologicals als used in the facility must be note with currently accepted oles, and include the	F 7	60		12/4/20
	§483.45(h)(1) In ac Federal laws, the fa	cordance with State and acility must store all drugs and d compartments under proper				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		245153	B. WING _			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 DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761	§483.45(h)(2) The faseparately locked, prompartments for solisted in Schedule II. Abuse Prevention and their drugs subject facility uses single and systems in which the and a missing dose. This REQUIREMENT by: Based on observation review the facility fanct expired and had a medication carts. Findings include: During an observation p.m. registered nursured facility had epineph RN-B unlocked the abox that containe 0.3-milligram injection stated according to expired March 2020 did not have a pharmindicated he was not had come from. RN confirmed the medicand that the box did stated if we needed emergency kit. Bottom in the separately stated according to the stated if we needed emergency kit. Bottom in the separately stated according to the stated if we needed emergency kit. Bottom in the separately stated according to the stated if we needed emergency kit. Bottom is separately stated according to the stated if we needed emergency kit. Bottom is separately stated according to the stated if we needed emergency kit. Bottom is separately subject to the separately stated in the separat	is, and permit only authorized access to the keys. facility must provide bermanently affixed atorage of controlled drugs of the Comprehensive Drug and Control Act of 1976 and to abuse, except when the unit package drug distribution are quantity stored is minimal can be readily detected. It is not met as evidenced ion, interview, and document alled to ensure medication was at the appropriate label in 1 of ion on 10/21/2020, at 5:22 are (RN)-B stated that the rine in the medication cart. cart and opened the drawer;	F 76	N/A All residents with orders for Epiper the potential to be affected. Alixa Pharmacy "Medication Label policy reviewed and remains curre All licensed staff and TMAs will be educated on Medication Labels pot the nursing staff trainings on 12/1 12/2. Medication Carts will be audited for expiration dates 1x/week for 4 were Administrator/Designee is response compliance. Results of monitoring shall be reported facility Quality Council meeting ongoing frequency and duration to determined through analysis and rof results.	ent. collicy at and or eks. sible for corted at g with o be	

PRINTED: 11/25/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	107	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 761	director of nursing of should have not be appropriate medical medications that we removed from the cor wasted. A facility policy was	age 97 on 10/22/2020, at 8:00 a.m. (DON) stated the medication en in the cart without the ation label and stated ere expired should have been eart and returned to pharmacy as requested and not received. Preferences, Substitutes	F 7			12/4/20
SS=J	CFR(s): 483.60(d)(§483.60(d) Food an Each resident receives §483.60(d)(4) Food allergies, intolerand §483.60(d)(5) Appendictive value to refood that is initially different meal choice	4)(5) Ind drink dives and the facility provides- If that accommodates resident des, and preferences; It is a commodated that accommodates resident des, and preferences; It is a commodated that accommodates resident desired that accommodates resident desired that accommodate resident desired that accommodate resident desired that accommodate resident desired that accommodate resident desired that accommodates desired that accommodates resident desired that accommodates desired that accommodate desired that ac				12/4/20
	Based on observareview, the facility for were served in a mallergen for 1 of 1 representation in the served in a mallergen for 1 of 1 representation in the served in an immediate for R5 when he was contained peanuts.	tion, interview and document failed to ensure food items anner to accommodate known esidents (R5) who had a fanuts, and history of fon (a severe, potentially life reaction) to peanuts. This rediate jeopardy (IJ) situation is served food items which		R5's allergies and care plan have reviewed and remains current. All residents with food allergies remained and remains current has potential to be affected. Meal Tray Identification policy has reviewed and remains current. All resident diet tray cards, as parabatement plan have been reviewed resident food allergy information electronic health record data to versident.	esiding at ave the s been rt of the ved for per	

CLIVILI	TO I OIT WILDICAIL	. A MEDICAID SERVICES			<u> </u>	VID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMI	SURVEY PLETED
		245153	B. WING			10/3	2 3/2020
NAME OF I	PROVIDER OR SUPPLIER			6.	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	23/2020
NAME OF F	-NOVIDEN ON SUFFEIEN						
MADON	NA TOWERS OF ROC	HESTER INC			001 19TH AVENUE NORTHWEST		
				K	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	dessert than what F	ary staff served a different R5 ordered from the dietary	F 8	306	accuracy. As part of the abatement plan, resi		
	administrator and dinformed of the IJ o	n allergy to nuts. The lirector of nursing (DON) were on 10/21/20 at 6:45 p.m. The			diet cards had a red dot added to be attention to a food allergy. As part of the abatement plan, culing the staff were advected on March Travers.		
	was removed on 10 non-compliance rer	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			staff were educated on Meal Tray Identification policy and using and following diet cards and again at st meetings on 12/1 and 12/2.	aff	
		han minimal harm that is not			Culinary staff will have daily pre-moservice huddles at lunch and dinner meals to review resident diet change.	r	
	Findings include:				with all culinary staff. A communication book will also identify changes for	ition	
	R5's Face Sheet in heart disease and o	cluded diagnoses of a stroke, dementia.			Food items that contain known res food allergens will be labeled so se staff will be informed to avoid servi	ident erving	
	assessment dated	mum Data Set (MDS) 9/17/20, indicated R5 had and speech, understood and			these items and alternate options provided.	9	
	was able to compre questions for the br	ehend. R5 refused to answer ief interview for mental status			Diet cards and labeled food will be audited 3x/week for 4 weeks for die		
		signs and symptoms of dependent with bed mobility, nd toileting.			accuracy and food allergens. Administrator/Designee is respons compliance.		
		nutritional status dated an allergy to nuts, specifically ws.			Results of monitoring shall be reported the facility Quality Council meeting ongoing frequency and duration to determined through analysis and reformed through analysis and results.	with be	
	stated he recently r peanut butter and s peanuts. R5 stated recognized the pea stated he had a "lig	on 10/20/20, at 9:06 a.m. R5 eceived a dessert containing stated he was allergic to after taking a small bite, he'd nut taste and spit it out. R5 ht asthma attack," adding			OI TESUILS.		
		and I was bent out of shape. I damn right I was scared."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	MPLETED
		245153	B. WING			C / 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP COI 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 806	R5 stated he didn't added, "it took a go system." Review of R5's pro 6:07 p.m. registere R5 was anxious an bite of a peanut wh reported to RN-B h and when he tasted out. At 7:04 p.m. R received an order figiven only if R5 was ymptoms of shortr gastrointestinal synclosely and did not an allergic reaction epinephrine. A prior incident fror documented in the of R5's reaction to included: "Rt [residingested the desse Rt. has a documen he had a small bite stomach. Rt. unablallergic reaction but 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] notifipt. to ER via [ambut of the control of the con	ge 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 aptoms. R5 was monitored develop signs or symptoms of and did not require 1 9/28/19 at 6:40 p.m., was record indicating the severity nuts. The documentation ent] reported that he had at that had peanut butter in it. ted allergy to nuts. Rt. stated at Rt reported an upset e to state symptoms of last twhen asked if his mouth or the responded, 'yes'. Rt. (alert and oriented times 4) swer all questions clearly. No thing, itching or mouth WNL (vital signs within nart. On call for [doctor name], ed and gave orders to send lance name] emergently. Pt's ified. Report called to [name	F8	06		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED				
		245153	B. WING			10	C 0/ 23/2020
	PROVIDER OR SUPPLIER	HESTER INC		4001 19TH	ORESS, CITY, STATE, ZIP CODE AVENUE NORTHWEST ER, MN 55901	1 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 806	During an interview cook (C)-C stated a kitchen and then do nursing home, refer kitchen." C-C stated main kitchen with in the server to make C-C stated R5 had for dinner on 10/5/2 bar which contained know how this occur. During an interview culinary services diresidents were give to fill out for the next allergies, their men their allergies; CSD his allergy to pean 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 innot receive the cool CSD-A verified their culinary staff to know items to ensure a refor which they were incident report had received food for w stated it would be a worker (SW). When	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 peanut butter. C-C did not	F8	06			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245153	B. WING			10/2	3/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIF 4001 19TH AVENUE NORTHWES ROCHESTER, MN 55901		10/2	.0,2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 806	know. During an interview SW-A stated she has cotch-a-roo bar maleader meeting. Swaperson who discover incident report, additionally nursing." During an interview the director of nursing aware R5 received peanuts on 10/5/20 on duty that evening and added, "I'm sur DON stated she would be aware to nursing provided a docume week 1, Thursday" of food items to ser document did not in food items, LC-B stresponsible for determined the plate to a tray and added condessert items to ea food were delivered from the main kitch.	on 10/21/20, at 11:03 a.m. eard about R5 receiving the ade with peanut butter at a V-A stated it was up to the ered the event to fill out anding "in this case, it was on 10/21/20, at 11:09 a.m. and (DON) stated she was not a dessert which contained by the DON stated the nurse grand I wasn't notified." The bould follow up with RN-B. The bould follow up with RN-B. The facility and delivered in metal and care for distribution. LC-B and the indicated the quantities and to nursing care. While the adicate ingredients for any ated nursing care was ermining resident allergies. 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 ch tray. DA-A stated pans of the nursing care kitchen en in steel containers and put A stated desserts arrived	F8	06			

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	
		245153	B. WING				C 23/2020	
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP 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 CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE	
F 806	plated with plastic of cart on wheels. DA-individual resident's order to plate the for cards included namilikes, dislikes and for verified R5's diet canuts: cashews and DA-A stated he was 10/5/20, when R5 in DA-A was unaware scotch-a-roo bars a looked like butters owent by the menut to served and on 10/5 they were serving some dies (DA)-B, (DA)-did not know there is scotch-a-roo bars. It o articulate the difficulate the diffic	ever the top, in a tall enclosed at A stated staff looked at the a paper menu and diet card in a daccurately. Resident diet are, room number, allergies, and preferences. DA-A and indicated an allergy to peanuts. It working the evening of ecceived the scotch-a-roo bar. The kitchen brought over and stated he thought the bars otch bars. DA-A stated staff to determine the food being 1/20, there was no indication cotch-a-roo bars. If with dietary staff on imately 6:55 p.m., dietary and (DA)-D, indicated they were nuts or peanut butter in a addition, they were not able erence in appearance ch bars and scotch-a-roo des verified no one had talked the incident on 10/5/20. They were no changes made to arring again, nor did they g. DA-B stated they talked that night and just decided	F8	06				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245153	B. WING			C /23/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	1 10	23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 806	scotch-a-roo bars. bars were periodical nursing care and withow they contained "they wouldn't." The facility policy to dated 2012 indicated A tray card (or approfor each resident reculinary services deconforms to physical dislikes and individed resident are being of the culinary service providing an accurate with diet conforming which contains the information, updatedName (first areRoom numbedDiet exactly areFood prefereredKnown food areSpecial needs substitute) The tray card with corresponding tray The immediate jeon was removed on 10 could be verified the had implemented a residents were not were allergic. Staff	out it was changed to CSD-A verified scotch-a-roo ally served to residents in hen asked how staff would ad peanut butter, he verified sitled Meal Tray Identification, ed: roved alternative) is provided aceiving meals from the epartment, to ensure that meal ain diet order and that likes, ual special needs of the met. es director is responsible for ate tray card for each resident, and following minimum and as needed: and last) r s physician ordered ference nees	F 8	606			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245153	B. WING			C 10/23/2020
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP C 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	CODE	10/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E E APPROPRI	
F 806	changes, a red dot bring attention to fo cards and food mer ensure adherence to preferences. During which contained kn labeled in order for addition, the facility food allergies on dividentified in the resirecord. Staff education policy cards, began on 10 be conducted prior staff worked. A combeen established to changes. Lastly, an culinary manager overify they were accessive and food to be a conducted prior staff worked.	was added to diet cards to od allergies. Review of diet nus were followed by staff to to resident food allergies and 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 a identify resident diet audit was conducted by the r designee, of diet cards to curately labeled for diet allergens. Audit results were	F8	306		



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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. 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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Pig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					C	
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE N STER, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any 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 tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	abbreviated survey compliance with Sta was found to be NC State Licensure. Pla electronic plan of co	TS: 20 through 10/25/2020, an was conducted to determine ate Licensure. Your facility of in compliance with the MN ease indicate in your prrection that you have ers, and identify the date				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/24/20

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF COMPLETE					
,	0. 00		A. BUILDING:			
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 559	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 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	olaints were NOT				
		led in ePOC and therefore a uired at the bottom of the first				
2 800	MN Rule 4658.051 Staffing requiremen	0 Subp. 1 Nursing Personnel; nts	2 800			12/4/20
	home must have of number of qualified registered nurses, nursing assistants residents at all nurs in all buildings if mo	requirements. A nursing n duty at all times a sufficient nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, cements.				
	by: Based on interview facility failed to ens and meet the asset (R11, R12, R13, R	ent is not met as evidenced and document review, the ure sufficient staff to provide ssed needs for 4 of 4 residents 14) who voiced concern with affing in the facility. The lack of		Corrected		

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10/2	0/2020
MADON	MADONNA TOWERS OF ROCHESTER INC 4001 197 ROCHES			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 2	2 800			
	sufficient staff had t residents who residents	the potential to affect all 50 led in the facility.				
	Findings include:					
	diagnoses of Parkir affecting movemen debility, osteoporos	rinted 10/23/20, indicated nson's disease (disease t), age-related physical sis (a condition in which bones brittle), muscle weakness and				
	assessment dated cognitively intact, h impaired vision req speech, was under comprehension. R1 assistance of two s and toileting, and e	nimum 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 xtensive assistance of one for the her room and locomotion on				
	would reach maxim and improve ability living (ADL's) for ba oral care. The care assistance with ever incontinence care as	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	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				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE 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." Fare their famous wousing my walker to kids say don't do the During an interview R12 stated, "If they doing good, and I devery 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 at, 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."				
	diagnoses of ataxia coordination), dege	erinted 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 comprehensic assistance of one s 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 to participate in activities of while able. R13's care plan ired assistance for bathing,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00419	B. WING		40/2	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/2	3/2020
	NA TOWERS OF ROC	4001 19TH		ORTHWEST		
ROCHE			ER, MN 55			
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 4	2 800			
	incontinence care a	oming, dressing, toileting, and ambulation. Staff se activities were identified as and nurses.				
	R13 stated in the la lost a lot of staff and stated, "I look at this personality, efficient stated, "Most of the don't treat us with repersonable." R13 stated and today I waited "They are short stated "Management push working double shift seeing good staff le R13 stated, "Personable."	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				
	R13 stated they use now have only one negatively impacted nursing assistant (N bath, "she can't hel not able to get to mused to have a rest use the bicycle and they are short staffe stated the new mar concerned about the residents. R13 states.	on 10/22/20, at 12:45 p.m. ed to have two bath aides and R13 stated this change dher, adding when her NA) had to give an evening pme and apologizes she is se sooner." R13 stated they corative aid and was able to walk in the hall, but now that ed, she doesn't walk. R13 hagement was more se bottom line than the ed, "I'm paying a lot of money or aren't always meeting my				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10.2	0.2020
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	diagnosis of demer debility, osteoarthri R11's quarterly Min assessment dated moderate cognitive hearing and vision, understood and har required extensive mobility, transfers a on and off the unit. assistance of one walking in the corristaff occurred only R11's care plan goa R11 maintain curre with activities of da plan indicated R11 compression stocking grooming, dressing and ambulation. Stactivities were iden and nurses. During an interview R11 stated she war have time." R11 stated she war have time." R11 stated she could not helped her walk. During a telephone p.m. family membe doing very well. FN (soiled herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped herself) quit FM-E stated, "To get the stated she could not helped she	rinted 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 bed and toileting and locomotion R11 required limited when walking in room, and dor with assistance of one	2 800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	MADONNA TOWERS OF ROCHESTER INC 4001 197 ROCHES			ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	call the facility to as just falls on deaf ea overwhelmed and s what's happening."	e." FM-E stated, "I've had to sk them to help toilet her and it ars." FM-E stated, "They're sympathetic, but I don't know	2 800			
	diagnoses of osteo bones), kyphosis (f obesity and muscle					
	assessment dated cognitively intact, h impaired vision req speech, was under comprehension. Rassistance of one s dressing and toiletin assistance of one was to the comprehension of the comprehension.	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 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	on 10/19/20, at 1:13 p.m. absolutely was not" enough are needs. R14 stated, "I can and I've had to wait as long as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	4001 19Th	AVENUE N	ORTHWEST		
WADONI	VA TOWERS OF ROC	ROCHEST	TER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 7	2 800			
	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 terrib leaving; they don't I have to do and don R14 stated when lowere 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 worker show." R14 stated stat	tated, "I take prune juice, have to go, so I try and go by d, "I'm having to do things on a supposed to do." R14 stated, it have enough help and he year I've been here; it's oly." R14 stated, "Staff is like the amount of work they "I like mandated overtime." Ing call lights and staffing resident council, "It got a bit ininistrator backed away from it ubject, he didn't want to talk d, "It was evident we weren't he as he cut us off." R14 supposed to be our home, R14 stated, "Feels like a war are and whoever is running the she heard this used to be a low it was considered only two				
	nursing assistant (Nenough staff." NA-A when the new admi work was added wi stated there used to residents, but one k NA-A stated randor assist with baths or this means there are the floor to assist relights. During an interview trained medication is different lately but the staff of the s	on 10/19/20, at 10:29 a.m. NA)-A stated, "There is not a stated staff starting leaving inistrator came because more thout enough staff. NA-A be two bath aids for 60 both aid was taken away. In aids are now assigned to a evening and weekends and the less nursing assistants on esidents and answer call on 10/19/20, at 2:21 p.m. aid (TMA)-A stated, "Staffing t nothing anyone can control" was trying. TMA-A stated a				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MADONNA TOWERS OF ROCHESTER INC			I 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 800	positions, adding the more than usual. The younger and the joint TMA-A stated, "It's assistant, but when they bargained for." lot of open position right now. TMA-A stated nursing assistate what might not get TMA-A stated, "profast when they put there was not enough the work and acting as a resprovided safe care, to burnout and staff. During an interview (RN)-A stated most RN-A stated "it see lately." RN-A stated but the nursing assistants the assistant to stay low hours. "RN-A stated nursing assistants hours, so if they wo hours." RN-A stated agency staff and respectively.	ft and no one was applying for here were a lot of pool staff, MA-A stated new staff were to was not what they expected. Heasy to become a nursing a they get into it, it's more than "TMA-A stated there were a stand a lot of chaos going on tated they were working short and they were to residents very their call lights on." You not 10/19/20, at 2:57 p.m. (N)-C stated at times that gh staff. RN-C stated as the staff. All they are wound care, as wound care, as wound care, as wound care, and they are they but added short staffing leads	2 800				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					С	
	00419	B. WING		10/2	23/2020	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MADONNA TOWERS OF ROCHES	STER INC	H AVENUE N TER, MN 559				
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 800 Continued From page	9	2 800				
	e tried to help them with					
the director of nursing can't find staff to fill por received push back at taking new admissions census for the staff the of agency staff, DON s adequately staffed, yet outcomes such as falls increase in incontinent seen an increase in se increase of associated it was like a ticking tim would eventually happ to the DON, there were human resources but s applicants and our curn DON stated they were managers, so the nurs to resident care and the "Staffing was taking all is getting done." DON what they have to do the improved." DON stated care residents deserved. During an interview on (NA)-B stated she usual a break as there was to staff the staff of the staff o	in order to decrease by have. Even with the use stated they are not thad not seen negative is, pressure ulcers or ce. DON added they had elf-transfers, but without and falls. DON stated she felt in bomb, stating something in the area of the bomb, stating something in the area of the area of the bomb, stating something in the bomb, stating something in the bomb, stating something in the bomb, stating in the bomb, in the bom					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
						;
		00419	B. WING		10/2	3/2020
NAME OF PROVIDER	R OR SUPPLIER			STATE, ZIP CODE		
MADONNA TOWERS OF ROCHESTER INC			I AVENUE N TER, MN 559	ORTHWEST 901		
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
reside that m gone of call lig stated stress: I could buring (NA)-O stated they le schedi When presse reside walk re and st do it a attenti were withey u position expect responsimpose. During human hard to substate position stated base, family them to they general stress of the stated base, family them to they general stress of the stated base.	orning. NA-B due to lack of hts, turning, v , "I've seen li fulI go hom In't do." g an interview C stated staffi , "We hire ne eave." NA-C st ule, but don't asked what s ed for time, N nts." NA-C st esidents who ated, "Somet II." NA-C sta on of the DO vorking on hi sed to have a on was elimin ted to do it al nsibilities. Na sible to walk g an interview n resources n of ill nursing a antial moneta ons and for in they used to but current si about open p o come here ot applicants stated, "We g	the 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 e thinking about all the things on 10/21/20, at 8:42 a.m. In high 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 ated she had not been able to are on restorative programs hing 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." I on 10/21/20, at 4:30 p.m. manager (HR)-D stated it was assistant positions even with ry bonuses for full time ternal referral bonuses. HR-D have an employee referral raff no longer tell friends and positions, "they don't want and work short." HR-D stated, but not qualified applicants. The property of the policies of t	2 800	DEFICIENCY)		

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Minnesc	<u>ota Department of He</u>	ealth			
AND DIANIOE COPPECTION IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDELAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	·	COMPLETED
		00419	B. WING		C 10/23/2020
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE. ZIP CODE	
		4001	19TH AVENUE N		
MADON	NA TOWERS OF ROC	HESTER INC	HESTER, MN 55		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 800	Continued From pa	ige 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 thired, who had resi in orientation. FM-C offer reimbursemer bonuses. FM-C stated an 8/80 work week July and "some stashifts." FM-C stated speed up the hiring increase wages. FM homes are in the samarket, too many be the same people." I compete with local wages. FM-C state putting individuals to course, paying for the full time position.	in the last three years, and ce they haven't worked. To tated it was difficult competed. During the same interestal. During the same interestal workers do not show g was discussed at leader alk about who was being gned, where new hires were stated as a corporation, at tuition, loan forgiveness ted, "Corporate changed if to a 40 hour work week in the stated incentive to pick up they were looking at way 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 Best Buy and Hobby Lobb did they were considering through a nursing assistant the course and giving there	nat's sting view, ing view, ing view, ship streethey and from streethey and streethey are streethey are streethey and streethey are		
	corporate vice pres stated, "In this indu challenged, we are to meet the needs of stated there was a	on 10/22/20, at 11:07 a.n ident of operations (VPO) stry, we are all staffing trying to ensure we have of our residents." VPO-G culture issue at this facility where it's been allowed	-G staff		
	resident needs was staffing and how ex stating "leadership providing guidance	not being able to meet a a combination of short disting staff were working, needed to be on the floor "The administrator stated ened at the facility with			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
		00419	B. WING		10/2	; 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	A TOWERS OF ROC	HESTER INC	_	ORTHWEST		
		ROCHES	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 12	2 800			
	and trying to rebuild "We staff some pre- care concerns were inefficiencies.	n leadership, staff quitting, d. The administrator stated, tty good ratios" and resident e more related to staff Staffing and Daily Work				
	Assignments dated Purpose: to ensure accordance with re-	2018, indicated: staff provide cares in				
	and competency ne services for all resident care plans All nursing service work assignment at	decessary to provide care and dents in accordance with and the facility assessment. personnel shall follow daily nd perform assigned duties in ofessional standards of				
	of direct care staff a	rs and the skill requirements are determined by the needs sked on each residents plan of				
	should be directed 3. Certified nursin trainees carry out th profession manner	oncerns relative to staffing to the administrator/designee. g assistants (CNAs) and neir daily assignment in a and in accordance with procedures and protocols.				
	1. Person-centered based upon needs included Quality of assistance, bowel a support, and rehabit 2. Staffing is plant based upon census	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. ned in advance and altered in all departments. In nursing are altered based				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			SURVEY LETED
		00440			40/0	
		00419			10/2	23/2020
	PROVIDER OR SUPPLIER	4001 19TH		ORTHWEST		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 13	2 800			
	upon resident need and discharges.	and the number of admission				
	facility administrator revise policies and adequate staff are a a timely manner and A designated staff cassure cares are beare supported to achighest practicable psychosocial well-beares.	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	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			12/4/20
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des and 4658.0405. A be out of bed as muis a written order from the custodial from the cu	general. A resident must e 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 remain in bed.				
	by: Based on interview	ent is not met as evidenced and document review, the nitor and assess for change of		Corrected		

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND BLAN OF CORRECTION IDENTIFICATION NUMBER:			` /	LETED		
					_	,
		00419	B. WING		10/2	3/2020
		00419			10/2	.3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	_	ORTHWEST		
		ROCHES	TER, MN 559	901		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
		,		DEFICIENCY)		
2 830	Continued From pa	ge 14	2 830			
2 000	•		2 000			
		d to follow physician orders,				
		R2) who had a history of				
		egs and respiratory concerns				
		pulmonary emboli (PE, clots in				
	0 /	sult of the facility's failures, an (IJ) situation was identified				
		played respiratory distress				
		w oxygen (O2) saturations,				
		se in oxygen and emergent				
		oital emergency room (ER).				
		pardy began on 9/25/20, when				
		end R2 to the ER per orders				
	and was identified					
	administrator, direc	tor of nursing (DON), licensed				
	social worker (LSW), culinary director, and				
	•	nist were notified of the				
		/ at 12:45 p.m. on 10/21/20.				
		pardy was removed on				
		m., but noncompliance				
		ver scope and severity level of				
		and severity level, which				
	jeopardy.	rm that is not immediate				
		lity failed to manage, monitor,				
	· ·	of bowel medications to				
		n for 1 of 1 residents (R8),				
		is of constipation and was on				
		ife care; and failed to monitor				
		and symptoms of fluid				
		physician orders for 1 of 2				
		a diagnosis of stage 3				
	(moderate) chronic	kidney disease.				
	Findings include:					
		imum Data Set (MDS)				
		9/6/2020, indicated R2 had				
		impairment and required				
		ce from two or more staff for				
		ansfers and required extensive				
	assistance from on	e staff for toileting, hygiene,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00440	B. WING		10/0	
	00419	D. WING		10/2	3/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWERS OF ROC	HESTER INC	I AVENUE N TER, MN 559	ORTHWEST 901		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
required oxygen, we medications, and he R2's Face Sheet, in embolism, deep verifications, and he R2's Physician star following: Initiate and 1-4 l/min (liters per PRN (as needed) for breath), hypoxia (0 update provider with R2's care plan date experienced hypertidentified to include ordered, check blood observe for signs of including; dizziness care plan did not accoutlined in Require hospital Discharge vein thrombosis (Acclots form in veins and PE (pulmonary which a blood vessiby a blood clot). R2's hospital Discharded 9/14/2020, he Issues Requiring Fincluded, Continue lower extremity for swelling, evidence (diminished pulse, new/worsening pai weakness) and any breath, chest pain,	MDS indicated R2 had not as administered anticoagulant ad a surgical wound. Included diagnoses of acute ing thrombosis (DVT) of right (Ided 9/14/2020), and (Ided 9/14/2020), and (Ided 9/14/2020). Inding orders included the ind titrate supplemental 02 at minute) via nasal cannula or dyspnea (shortness of 2 saturation <90%); and to the nursing assessment. Interventions were administer medications as od pressure per order, and of high blood pressure so, chest pain, dyspnea. The ddress the instructions as d Follow Up section of the Summary to monitor for deep condition in which the blood located deep inside the body) of embolism-A condition in the lung(s) gets blocked as section called, Active ollow-up. This section close monitoring of the right propagation/worsening of of neurovascular compromise	2 830			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			7t. BOILDIIVO.			
		00419	B. WING		10/2	, 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	LA TOWERS OF BOO	4001 19TH	AVENUE N	ORTHWEST		
MADONI	NA TOWERS OF ROC	ROCHEST ROCHEST	TER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
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 w coloration of right losurgery 5 centimete R2's physician visit recapitulation of hodischarge 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.	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 or active surveillance of the y, monitoring for pulmonary embolism, d oxygen requirements. The ing reported increased oxygen y with physical therapy, and quested order to increase sessions. Resident denied h, chest pain, numbness and mity. The note indicate the nsult with vascular clinic for Physical exam, skin: Purple	2 830			
	right leg. The note sounds and "3. Nur monitoring of right l	right lower leg. Edema +1 included orders for ultra sing will continue close ower extremity for swelling, bulse, numbness/tingling,				
	new/worsening pail weakness, shortne and/or hypoxemia t pulmonary embolis	n in the distal extremity, ss of breath, chest pain, hat may suggest possibility of m."				
	p.m. indicated a tel from the NP (nurse be increased to 3 lp "Resident noted to subsequent note at	e dated 9/15/2020, at 4:21 ephone order was obtained practitioner); oxygen needs to om to keep Sp02 above 90%. de-sat with exertion." A 9:49 p.m. included the ultra DVT is seen in bilateral lower				

Minnesota Department of Health STATE FORM

	ta Department of He		. ()(0) MUU TIDI	E CONSTRUCTION	()(0) DATE	OLIDY (E) (
AND DUAN OF CODDECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
711012711	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
			B. MINIO)
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10 101	TO VIDER OR GOLF EIER			ORTHWEST		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55			
(V4) ID	SHIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ige 17	2 830			
	-					
	extremities."	data d 0/16/2020 at 2:01 % m				
		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				
		// PT limiting time to assess				
		6 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				
	20 sec and had pt s	stop. Pt took 1 min 20 sec to				
		ed O2 SATS to do quick wean				
	back to room air an	id at [sic] was in 80's and				
	quickly above >90.	Monitored to 2 lpm, 1 lpm and				
	to room air w/ pt at	100% by end. Notified nurse				
		v/ activity as nurse arrived to				
	give meds."					
		dated 9/17/2020, at 11:39				
		for 1 minute, and PT would not				
		nger to ass O2 sats/tolerance.				
		fter standing and O2>90%				
		sitting, O2 eventually dropped				
	to 81% after sitting					
		100%. Pt stood 2nd time and				
		O2 dripped to 85% quickly				
		wn with O2 dropping to 74%				
		o recover. Discontinued				
	standing attempts a					
		dated 9/18/2020, at 11:13				
		lenied feeling any shortness of				
	pream and did not	display symptoms when laying				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	-	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00419	B. WING			3/2020
		00410			10/2	.5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC 4001 19TH	H AVENUE N	ORTHWEST		
MADONI	VA TOWERS OF ROC	ROCHES.	TER, MN 55	901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				22.10.2.10		
2 830	Continued From pa	ge 18	2 830			
	down. A subsequer	nt note at 1:13 p.m. included,				
		the following concerning tx				
		d asleep in w/c w/ lunch tray,				
	on room air. O2 SA	TS 84% on R [right] hand and				
	compared to L [left]	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				
		eep 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				
		ning. 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				
	60's to 100% while					
		ed nurse telephone encounter				
		20, at 1:23 p.m. included, "Call				
		e [name of nurse] at Madonna				
		vas in PT [physical therapy]				
		saturation was checked.				
	Room air sats were	95%. Nurse states that				
	resident's 02 sats w	vere going as low as 50% with				
		at rest. Resident appears in				
		s. No shortness of breath or				
		scoloration) noted. Writer				
		of unit used to test. She				
		ed with another machine and				
	0 0	me kind of readings. She				
		re "all over the place" at				
		positions. Writer requested				
	an S-bar be sent w	ith updated vitals. Resident				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00419	B. WING		10/2	; 3/2020
NAME OF	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	10/2	0,2020
		4001 19TH		ORTHWEST		
MADONI	NA TOWERS OF ROC	ROCHES1	TER, MN 55	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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	remains on 3L of 02 R2's follow-up phys 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 DV7 embolism, I gave o [hospital name] ED R2's physician note p.m. included "NP or 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 it Assess for SOB [sh cough, dizziness/lig pain or swelling wh R2's progress note indicated the physic recommended send room for further eval services was called evaluated her and of hospitalization at the 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 "Bili venous thrombosis R2's record lacked	2. sician's note dated 9/18/2020, ed "Called facility and talked to 2 sat reading was all over the low as 50% and they're acy of the equipment. admitted to [name of hospital] T. With concern for pulmonary reder to send her back to ". e dated 9/18/2020, at 2:25 called [nurse name], who inbulance came, EMT cound her 02 sat was normal. e's stable and did not take her was instructed to keep a close a 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 in 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	2 830			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURVEY		
AND LIMIN	OI CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:	·	COMPLETED	
		00419	B. WING			3/2020
NAME OF I		etdeet M	DDDESS CITY S	STATE ZID CODE	-	
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE N			
			STER, MN 55			I
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 830	Continued From pa	age 20	2 830			
_ 000	•					
		note dated 9/22/2020,				
		een for initial physician visit.				
		a section Physical Exam; the				
		ed "Constitutional: She				
		oped. Psychiatric: She has				
		affect." 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				
		1. oxygen was 67 at 4 L. Her				
		I to touch. She was covered				
		and was monitored for an hour				
		en with nasal cannula.	,			
		lled and she was transferred				
		e note lacked documentation				
		peen notified of R2's oxygen				
	saturation less than	n 90% and acute change in				
	condition.					
		dated 9/28/2020, indicated				
	_	e facility and reported R2 was				
	close to death.	10/00/0000				
		y on 10/20/2020, at 6:22 p.m.				
		1)-A stated on 9/23/2020, she				
		and received a call from a				
		before 4:00 p.m.; the nurse be going into the emergency				
		gent cares. FM-A stated she				
		ry around 5:20 p.m. and				
		ne 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				
	stated R2's death of					
		ight hip fracture-fall,				
		Alzheimer's disease				

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	IT OF DEFICIENCIES	1	(VO) MULTIPL	E CONCEDUCTION	(V2) DATE	CLIDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		33 22.125	
					C	
		00419	B. WING		10/2	3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO HOLE OF	THOUBER OR COLL FIELD			ORTHWEST		
MADONI	NA TOWERS OF ROC	HESTER INC	TER, MN 559			
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX	-	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ige 21	2 830			
	On 10/21/2020 at 8	8:00 a.m. director of nursing				
		2's oxygen saturation records				
		nitoring and assessing of				
		as lacking, there was				
		entation of how much oxygen				
		d therefore would not be able				
		ning respiratory condition."				
		5/2020, upon discovery of				
		, 911 should have been called				
	as well as the phys	ician instead of monitoring R2				
		ON 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."				
		on 10/21/2020, at 3:03 p.m.				
		N)-C indicated if resident had				
		ions, would check standing				
		ygen and call 911 and/or				
	physician depende					
		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				
		p.m. when it was determined				
	the facility provided					
		to licensed nursing staff on e of condition policy with				
		mal respiratory status and				
		pulmonary embolism. In				
		developed and implemented				
		for respiratory monitoring.				
	R8 CONSTIPATION					
		inge Minimum Data Set (MDS)				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		COMPLETED	
						,
la umia						3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•	
10 10 1	TOVIDER OR GOLF EIER		, ,	ORTHWEST		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG	REGOLATORT OILE	oo ibentii tiivo iivi orvii (iiov)	IAG	DEFICIENCY)	TUTUL	
2 830	Continued From pa	ne 22	2 830			
	•					
		7/23/2020, indicated R8 had				
		ospice, did not have cognitive				
		d not have rejection of care ng to the MDS, R8 required				
		be from two or more staff				
		nobility, dressing, and toilet				
		cated R8 was always				
	incontinent of bowe					
	R8's Face Sheet, in	cluded 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 with through collaboration				
		d of life care." Interventions				
		er medications as ordered,				
	,	ent effectiveness of				
	medication. Follow-	-up with hospice/provider as				
		ation care plan edited on				
	,	d R8 had alteration in				
		to decreased mobility and				
		vith the goal of "will have no				
		ns] of constipation through the				
		dated 6/29/2020). The				
		led, administer medications as ve for effectiveness, see				
		care plan (7/28/2020), If no				
		three days follow bowel				
		ng orders (6/29/2020),				
		constipation: passing hard/no				
	stools, abdominal b	loating/swelling, cramping,				
		iting, mental status changes				
		of one stand pivot wheelchair				
	to/from toilet.	and the standard state of the state of				
		ers included the following:				
		rate solution 5 milligrams (mg)				
		y mouth every hour as ss of breath or pain (start date				
	HEEGEN TOT SHOUTHE	oo oi bicaiii oi paiii (Stait uale				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER						SURVEY LETED
		00419	B. WING		10/2	23/2020
	PROVIDER OR SUPPLIER	HESTER INC 4001 19	DDRESS, CITY, S TH AVENUE N STER, MN 55			
(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 APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	7/18/2020, end date-Lactulose (laxative PRN for constipation date 8/5/2020) -Lactulose 15 ml by take 15 ml daily as date 7/15/2020, end-Lactulose 30 ml twend date 8/11/2020 -Senna with Docust two tablets in the mbedtime (start date 7/28/2020), order wtake 3 tabs twice a 8/11/2020 -Bisacodyl 10 mg s (start date 7/19/202 -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 traconstipation if no redate 8/2/2020, end Miralax 17 grams on 8/5/2020, end date Facility standing ordirector on 3/1/2019 Management include constipation; (Perforectal check to determine the standard of the	e 8/9/2020) e) 15 milliliters (ml) once a day on (start date 7/15/2020, end on (start date 7/15/2020, end on (start date 7/15/2020, end of mouth daily and may also needed for constipation (Start date 8/5/2020) vice daily (start date 8/5/2020) vice daily (start date 8/5/2020) ate Sodium 8.6/50 mg, take forning and 3 tablets at 7/15/2020, end date 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 date 8/5/2020) mg by mouth once day (start 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	t e or			

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
0	0419	B. WING		10/2	; 3/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWERS OF ROCHESTER	RINC	HAVENUE N	ORTHWEST 901		
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
R8's Medication Administration combination with Bowel (BMR), and progress notes record consistently lacked bowel assessments; the rephysical examination such distention, presence of bowel abdomen. The record iden medications were not given and no follow up of effective medication was given. R8's progress note dated 7 R8 reported constipation "resuppository and laxatives" movement. R8's BMR identified R8 did movements on 7/23, 7/24, One PRN dose of Lactulos 7/25/2020; dose was documented frective, no further interved MAR indicated no PRN sumadministered. R8's MAR on 7/26/2020, in administered a Fleets ener special instructions: Day 4 order, with medium results p.m. indicated R8 had a late and at 7:22 p.m. had a mediconsistency of BM was not BMR. R8's BMR included the follogous progression of the follogous progression progr	Movement Record s were reviewed. The a comprehensive acord did not identify as abdominal wel sounds, or firm/soft tified bowel n per physician order reness when the bowel 7/22/2020, indicated relieved with had large bowel I not have bowel and 7/25/2020. Se was administered on mented as not entions documented. Spositories were adicated R8 was ma, one time with no BM per standing The BMR at 1:22 rge bowel movement dium bowel movement; a identified on the sowing recordings: I movement (no	2 830			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MADONNA TOWERS OF ROCHESTER INC (X4) ID PREFIX TAG CAUTH AVENUE NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective. -8/1/2020, no bowel movement - 8/2/2020, no bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective. -8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER	ED:	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	AND PLAN OF CORRECTION IDENTIFICATION NOWE	A. BUILDING:	COMPLETED
NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CA(4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE DATE 2 830 Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	00419	B. WING	_
MADONNA TOWERS OF ROCHESTER INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	<u> </u>		10/20/2020
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	MADONNA TOWERS OF ROCHESTER INC		
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Bisacodyl suppository administered day 4 no BM and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU	LL PREFIX (EACH CORRECTIVE ACTI DN) TAG CROSS-REFERENCED TO TI	ON SHOULD BE COMPLETE DATE DATE
and was not effective8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was	2 830 Continued From page 25	2 830	
-8/4/2020, medium bowel movement that was soft/formed. MAR indicated lactulose and Bisacodyl administered and were not effective 8/6/2020, no bowel movement; MAR identified Miralax was administered per schedule, no PRN bowel medications administered8/7/2020, no bowel movement; MAR identified scheduled medications given, Bisacodyl administered and charted as effective although there was no bowel movement recorded. R8 was administered morphine 5 mg at 4:52 p.m. for bottom pain 5/10; record lacked evaluation of effectiveness8/8/2020, small bowel movement that was dry and hard; MAR identified Bisacodyl administered for day 4 without a bowel movement; documented as effective. R8 refused Senna S, record lacked evidence after refusal R8 was re-approached. R8 was administered Morphine 5 mg at 2:58 p.m. for discomfort when trying to have bowel movement and shortness of breath, and at 4:58 p.m. for bottom pain8/9/2020, 2 small bowel movements (consistency was not identified); MAR indicated R8 refused suppository, Miralax, and Senna S8/10/2020, indicated R10 had small soft/formed stool, large loose stool, and another large bowel movement.	Bisacodyl suppository administered day 4 and was not effective8/1/2020, R8 had medium bowel movem was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective8/3/2020, no bowel movement. PRN Biss suppository and lactulose administered a not effective8/4/2020, medium bowel movement that soft/formed. MAR indicated lactulose and Bisacodyl administered and were not effective8/6/2020, no bowel movement; MAR ide Miralax was administered per schedule, robowel medications administered8/7/2020, no bowel movement; MAR ide scheduled medications given, Bisacodyl administered and charted as effective alth there was no bowel movement recorded. administered morphine 5 mg at 4:52 p.m. bottom pain 5/10; record lacked evaluation effectiveness8/8/2020, small bowel movement that was and hard; MAR identified Bisacodyl administered as effective. R8 refused Sen record lacked evidence after refusal R8 was administered Morning at 2:58 p.m. for discomfort when trying have bowel movement and shortness of the and at 4:58 p.m. for bottom pain8/9/2020, 2 small bowel movements (consistency was not identified); MAR ind R8 refused suppository, Miralax, and Sen -8/10/2020, indicated R10 had small soft stool, large loose stool, and another large	ent that codyl ad was was ctive. ntiffied b PRN dtiffied ough R8 was for n of s dry istered as S, as phine 5 to reath, cated ha S. formed	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ´COM		(X3) DATE	
VIAD L PVIA	INDITERNOT CONNECTION		A. BUILDING:		COMPLETED	
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE		
NAIVIE OF I	-ROVIDER OR SUPPLIER					
MADON	NA TOWERS OF ROC	HESTER INC	_	ORTHWEST		
	I		TER, MN 55	901		
(X4) ID	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
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17.0		,		DEFICIENCY)		
2 020	O	00	2 830			
2 830	Continued From pa	ige 26	2 030			
	"Resident complain	ing of discomfort in abdomen.				
	Has no bowel move	ement for 6 days. On				
	scheduled and as r	needed morphine sulfate. Oral				
	laxatives and Bisac	odyl suppository ineffective.				
		n as per standing order.				
	Effective with media	um hard stool. Resident				
		h abdominal discomfort." The				
		oral laxative encouraged.				
		dated 8/3/2020, hospice				
		not eating and need for bowel				
	medication due to d					
		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				
	PRN Bisacodyl sup	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				
		pice called the facility and				
		e to give prn dose of lactulose.				
		t lactulose and suppository				
		red later that afternoon. At				
		ily had communicated back to				
		pository and enema were used				
		hospice nurse called hospice				
		ined new orders. The note				
		would call hospice when R8				
		edications were given as				
	directed by hospice					

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NAME OF PROVIDER OR SUPPLIER MADONNA TOWERS OF ROCHESTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE A. BUILDING: A. BUILDING: C C T A. BUILDING: A. BUILDING: A. BUILDING: A. BUILDING: C C T T T T T T T T T T T		NT OF DEFICIENCIES NOF CORRECTION
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MADONNA TOWERS OF ROCHESTER INC ROCHESTER, MN 55901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	NAME OF PROV	PROVIDER OR SUPPLIEF
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(/// 15	(X4) ID	SLIMMARY ST
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENC
2 830 Continued From page 27 2 830	2 830 Co	Continued From p
R8's progress note dated 8/4/2020, at 1:09 p.m. indicated R8 reported constipation, scheduled bowel medication suppository and enema given per hospice order with small smeared results. "PRN morphine given for comfort during care, transferring, and discomfort due to constipation." The note indicated hospice was updated during visit and via phone related to bowel management. A subsequent note at 1:46 p.m. included, "STAT verbal order for another lactulose PRN per hospice for constipation placed." Note at 9:54 p.m. included, "Included, "STAT verbal order for another lactulose PRN per hospice for constipation placed." Note at 9:54 p.m. included, "State sonce dated 8/5/2020, indicated hospice at the facility and gave new orders; Bisacody! 10 mg daily and increase lactulose to 30 ml twice a day. A subsequent note at 7:50 p.m. indicated staff had reported R8 had large bowel movement during evening cares. According to R8's MAR on 8/5/2020, R8 was administered Morphine 5 mg at 3:23 p.m. for rectal pain, record did not identify the effectiveness of the medication. R8's progress note dated 8/8/2020, indicated took her bowel and pain medications. A subsequent note at 8:47 p.m. indicated cream was applied to residents bottom due to discomfort after bowel movement. R8's progress notes dated 8/8/2020, at 8:25 a.m. indicated hospice was updated related to pain management due to discomfort with direction from hospice to stay on PRN medications as ordered. The note indicated R8 was administered the pain medications and not good results. A subsequent note at 4:04 pm. indicated R8 had refused her morning medications. Family member was present, asked medications be	R8 ind box per "PI tran The vis main incomplate have plan have R8 hos Bis 30 p.n box Accading recomplate have effer R8 took sulf was dis R8 ind main from the sulf reference in the sulf reference has been supported by the sulf reference has be	R8's progress note indicated R8 reports bowel medication per hospice order "PRN morphine git transferring, and or The note indicated visit and via phone management. A strincluded, "STAT vollactulose PRN per placed." Note at 9 had a medium bown Results were come R8's progress note hospice at the facil Bisacodyl 10 mg of 30 ml twice a day. p.m. indicated state bowel movement of According to R8's administered Morprectal pain, record effectiveness of the R8's progress note took her bowel and subsequent note as was applied to residiscomfort after both R8's progress note indicated hospice management due from hospice to stordered. The note the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication subsequent note arefused her morning transfer in the pain medication in th

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERNCE TOTH SACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 28 "Resident started to have peristalsis (the involuntary constriction and relaxation of the muscles of the intestine or another canal, creating wavelike movements that push the contents of the canal 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. R8's progress note dated 8/10/2020, at 5:51 a.m. indicated R8 had a soft small bowel movement when she was repositioned. R8's progress note dated 8/10/2020, at 1:28 p.m. (late entry documented on 8/11/2020 at 1:40 p.m.) included, "Resident restless and c/o [complained of] pain." Note indicated R8 was administered pain medication and Haldol for anxiety. "This writer brought Bisacodyl suppository to her room to administer dit resident refusing oral bowel medications and only having
MADONNA TOWERS OF ROCHESTER INC A001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901
(24) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 28 "Resident started to have peristalsis (the involuntary constriction and relaxation of the muscles of the intestine or another canal, creating wavelike movements that push the contents of the canal 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. R8's progress note dated 8/10/2020, at 5:51 a.m. indicated R8 had a soft small bowel movement when she was repositioned. R8's progress note dated 8/10/2020 at 1:40 p.m.) included, "Resident restless and c/o (complained of) pain." Note indicated R8 was administered pain medication and Haldol for anxiety. "This writer brought Bisacody! suppository to her room to administer d/t resident refusing oral bowel medications and only having
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 28 "Resident started to have peristalsis (the involuntary constriction and relaxation of the muscles of the intestine or another canal, creating wavelike movements that push the contents of the canal 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. R8's progress note dated 8/10/2020, at 5:51 a.m. indicated R8 had a soft small bowel movement when she was repositioned. R8's progress note dated 8/10/2020, at 1:28 p.m. (late entry documented on 8/11/2020 at 1:40 p.m.) included, "Resident restless and c/o [complained of] pain." Note indicated R8 was administered pain medication and Haldol for anxiety. "This writer brought Bisacody! suppository to her room to administer d/t resident refusing oral bowel medications and only having
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NO suppository." Residents daughter was in the room at the time and agreed with residents request. Hospice here around lunch time and resident still having increased anxiety and restlessness" the note indicated the nurse tried to offer the suppository again and the resident refused. R8's hospice visit note dated 8/11/2020, included "RN did rectal check due to complaints of having rectal pain. [Name of nurse] LPN [licensed practical nurse] did not give suppository as requested by this RN on 8/11/2020 due to pt refusal. RN noted pt to have hard stool in rectum and disimpacted XL [extra large] hard stool. RN was unable to complete disimpactaction due to pt

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					С	
		00419	B. WING			, 3/2020
			l .		1 10/2	J. 2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	IA TOWERS OF ROC	HESTER INC	_	ORTHWEST		
		ROCHEST	ΓER, MN 559	901		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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2 830	Continued From pa	ge 29	2 830			
	have bleeding from	rectum in moderate amounts				
	(possible hemorrho	id). RN applied pressure to				
		down the bleeding. RN gave				
		itory to promote further BM.				
		pactive x 4. After pt was				
		as able to relax with no facial				
		ssness noted in bed." The				
		the resident was transferred				
	to hospice house.					
		on 10/21/2020, at 8:51 a.m.				
		NA)-D stated NA's were				
		bowel movements,				
		lidn't get charted, and didn't				
		ay to look back at the history.				
		rses were supposed to make				
		bowel movements and				
	administer supposit	ories if they didn't have one				
	every three days.	•				
		on 10/21/2020, at 9:23 a.m.				
	NA-C stated NA's v	vere supposed to document				
	bowel movements I	nowever, needed work. NA-C				
	indicated agency st	aff were not documenting.				
	NA-C indicated a si	uppository was supposed to				
	be given if a resider	nt did not have a bowel				
		ree days; that it was up to the				
	nurse to administer					
		on 10/21/2020, at 9:34 a.m.				
		urse (LPN)-A stated NA's				
		locument bowel movements				
		ırse if haven't had a bowel				
		s or if resident complained of				
		A stated TMA's have to check				
		holding any medications for				
		e completed. LPN-A stated				
		should be followed for bowel				
		wel medication was not				
		e follow-up was required.				
		on 10/21/2020, at 12:16 p.m.				
	registered nurse (R	N)-A stated there was a bowel				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					C	;
		00419	B. WING			3/2020
						0.2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC 4001 197	TH AVENUE N	ORTHWEST		
MADON	TA TOWEROOF ROO	ROCHES	STER, MN 55	901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DAIL
				- ,		
2 830	Continued From pa	ige 30	2 830			
	movement report s	heet. RN indicated the report				
	was supposed to be	e pulled up during the shift; if				
	no bowel movemer	nts in 3 days then a				
	suppository was su	ipposed to be given. RN				
	indicated if it was n	ot effective then more				
	follow-up was supp	osed to be completed. RN				
		powel assessment should be				
		the administration of bowel				
		when a resident would				
	complain of constip					
		on 10/21/2020, at 3:03 p.m.				
		RN)-C stated a complete bowe	I			
	assessment should					
		o the administration of				
		licated if no bowel movement				
		osed to get a suppository, and				
		ults then more intervention				
		oleted. RN-C stated				
		ot always accurate, and does				
		consistency; stated there isn't documentation and indicated				
		person recording to				
	determine difference					
	small/medium/large					
		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				
	what happened. DO	ON stated bowel assessments	;			
		ed when complaints of				
		before administering a PRN				
	medication.					
		one interview on 10/29/2020,				
		irse practitioner (NP)-B NP-B				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00419					10/2) 3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N TER, MN 559	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	stated staff should medications per ore enema should not prescribed medicate expectation that not assessments daily concerns and beformedications. R9 FLUID OVERLOR9's admission Mirassessment dated not have cognitive extensive assistant mobility, dressing at MDS also indicated administration of a assessment period R9's Face Sheet, in hypertension, venothe liver (scarring of disease stage 3 (morheumatic tricuspid heart's tricuspid vasecondary pulmona R9's nutrition care identified R9 was contented interventions included the search show intake and refured R9's Hospital Dischoverview dated 9/2 hospitalized related blood loss. The search should be	be administering bowel ders. NP-B indicated fleets be given before using the tions. NP-B stated an arses complete full bowel if there was constipation re administration of as needed DAD himum Data Set (MDS) 9/28/2020, indicated R9 did impairment and required to five or more staff for bed and personal hygiene. The did R9 received one diuretic during the holius insufficiency, cirrhosis of the liver), chronic kidney be derate kidney damage), insufficiency (failure of the live to close properly), and any hypertension. In plan dated 9/23/2020, and a fluid restriction; and decument meal intake %, ments, and urinary output as iff. Notify licensed nurse for sed meals. The live is an arge Summary Brief 21/2020, indicated R9 was did to anemia iron deficiency cition Active Issues Requiring I primary care provider to orsemide (diuretic) at dose of based on creatinine (lab)	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		7 BOILBING.			С
	00419	B. WING			23/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MADONNA TOWERS OF BOOK	4001 19T	H AVENUE N	ORTHWEST		
MADONNA TOWERS OF ROCH	ROCHES	TER, MN 559	901		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830 Continued From page	ge 32	2 830			
-Check heart rate, b (oxygen saturations) requirement) Special clinic staff] if SBP (start SBP <90, HR (he <90% or increased of other concerns (start 10/2/2020) - Check heart rate, be daily (include oxyge instructions: Notify [include oxyge instruction] (dizz syncope (start date 10/5/2020) -No added salt diet. restriction (start date -Weight daily before scale. Notify provide (pounds) or <261 lbs -Torsemide 10 millig daily in the morning -Apply low stretch wextremities, on in the (start date 9/28/2020 R9's vital sign record	blood pressure, and Sp02) daily (include oxygen al instructions: Notify [name of ystolic blood pressure] >160 eart rate) >100 or <60, Sp02 oxygen needs, or with any t date 9/24/2020, stop date blood pressure, and Sp02 n requirement) Special name of hospital staff] if SBP sure] >160 or SBP <90, HR <60, Sp02 <90% or eeds, or with any other rate <60 only notify provider iness/lightheadedness or 10/2/2020, stop date Special instructions <1.5 fluid e 9/21/2020) breakfast. Use the same er if weight gain >267 lbs. s. (start date 9/28/2020) breakfast. Use the same er if weight gain >267 lbs. s. (start date 9/28/2020) breakfast date 9/28/2020) breakfast date 9/28/2020) breakfast date 9/28/2020				

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, <u>5</u> 0. <u>.</u> 5			:
		00419	B. WING			3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		ORTHWEST		
ROCHES			TER, MN 559		211	
(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 APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 33	2 830			
2 000	9/27/2020, 9:48 a.r R9's 24 hour fluid in lacked documentat implemented R9's in 9/25/20, 9/30/20, 1 R9's daily weight re- revealed R9 had not days: -9/22/2020, wt. (weight not -9/23/2020, wt. not -9/24/2020, wt. 256 -weight not taken on 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, wt. not -10/6/2020, wt. not R9's record lacked monitoring and eval edema (swelling can accumulation in the evidence R9's physis increased weight to R9's progress note revealed the follow -9/21/2020, included (pressure applied to of 0-2 millimeters (in immediately) pitting extremities, with wr encouraged to elev -9/22/2020, included time. -9/28/2020, indicated	n. HR 55 htake from 9/21/20 to 10/5/20, ion the facility had fluid 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 hight) 264.7 lbs. taken 6.3 lbs. n 9/25, 9/26, 9/27, 9/28, or 6.2 lbs. taken 6.5 taken 6.6 taken 6.7 take	2 030			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					(0
		00419	B. WING		10/2	23/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	daily in morning and bilateral lower extreat night, ordered lal patient daily in fasti the same scale10/1/2020, 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 test10/4/2020, indicate and had increased called, physician direport any increased decreased intake, f test done right now-10/5/2020, include with her provider th overload and needi order to send reside R9's progress notes monitoring of fluid sconsistently per phy R9's physician note revealed the followi-9/28/2020, R9 had evaluation of hyper	d apply low stretch wraps to emities, on in the morning off os for 10/1/2020, and weighing state every morning using 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. p.m. indicated R9 had 3+ th legs. and R9 was having increased requency and yelling out, ared and faxed for request for and faxed for request for a confusion, physician was rected to closely monitor and a signs of confusion, arever, and did not want a urine and R9 was calm and slept all low up with SBAR today. And a meeting is morning. Likely in fluiding diuresis. Provider gave to emergency department. Is lacked documentation of status, edema or daily weights a special provider gave and slept all special provider gave and slept all special provider gave and slept all status, edema or daily weights a special provider gave and slept all sp		DEFICIENCY		
	target range of 261 not been weighed s	order for daily weights with a -267 lb. unfortunately she has since 9/24/2020 and her was 256.3 lb." The note also				

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STATEMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.2.7.2.11.0.7.001.11.1			A. BUILDING:			
		00419	B. WING		10/2	; 3/2020
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWI	EDS OE DOC	HESTER INC 4001 19TH	AVENUE N	ORTHWEST		
MADONNA TOWN	LING OF INOC	ROCHES	TER, MN 55	901		
			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830 Contin	ued From pa	ge 35	2 830			
indicate low, us diastoli started labs we week10/1/2 weight less that [skilled has be have be not beet today a docum have me for toda nurse a include extrem Her legindicate hypona follow of -10/5/2 Initially way to again a not log nursing however to call legindicate tomorrow time, if -10/6/2 yestero sympto	ed her blood sually 90's syic. The visit is related to here ordered, 2020, at 9:00 parameters an 261 lb or incomplete in very incomplete in very incomplete in very incomplete in ented in EM hade 3 sepanding with a made 3 sepanding with a made 3 sepanding in the plan very set in the plan very she was worthe bathroom at 11:15 a.m. on at 11:15 a.m	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 is point, there is nothing R [electronic medical record]. I rate attempts to contact SNF I have been unable to get a Towers." The note also loes report bilateral lower vorse in the right than the left. Itly wrapped." The visit note was to continue Torsemide for pred labs for 10/6/2020, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		7 50.25 10.		C	:
00419		B. WING		_	3/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWERS OF ROCHESTER INC		H AVENUE N TER, MN 559			
(X4) ID SUMMARY STATEMENT OF DEFICI		ID ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG (EACH DEFICIENCY MUST BE PRECED REGULATORY OR LSC IDENTIFYING INF	ED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
2 830 Continued From page 36		2 830			
today. At time of visit she appeared unable to answer questions other ther need to urinate." The note also "Per nursing staff [name of nurse] unwell and weak today, [name] states been confused for two days arexperiencing urinary frequency. [Natates that her eyelids appear to be note indicated R9 was alert to personant did not know where she was lend to indicated the physician gave at transfer to emergency room for decondition. During an interview on 10/21/2020 NA-C stated NA's tried to get daily however, it didn't always happen be were busy in the morning. Stated if weight then the bath aide would at the weight on the resident. During an interview on 10/21/2020 licensed practical nurse (LPN)-A stated she did not think it was bein and it would be important to identific condition. During an interview on 10/23/2020 director of nursing (DON) reviewed and confirmed weights were not of order, lack of edema monitoring areand the physician was not notified rate was below 60 per the order. Decompleting did identify if R9's was for symptoms for lower heart rate. During a return phone interview on at 3:30 p.m. with nurse practitioner stated completing daily weights at been an ongoing problem. NP-B st were given set parameters on whe physician and they were also giver	chan to voice of included, patient is stee that patient and has been ame] also eswollen." The son and year ocated. The an order to cline in 1), at 9:23 a.m. weights ecause staff f we miss a ttempt to get 1, at 9:34 a.m. tated edema ght. LPN-A g documented, y a change in the state of the s				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00419	B. WING		10/2	; 3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWERS OF ROCHESTER INC			HAVENUE N TER, MN 559	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	morning, before bro NP-B indicated that get the appropriate monitoring and assifluid balance, and so A facility policy/profession was requested and Facility policy Charincluded "When a stresident's physical, status is identified there is need to altolicensed nursing astending provider resident/resident renot specifically definity policy/profession was requested and Facility policy Admincluded; To adminsafe and accurate rights of medication are administered in 3. Medications are prescribed time. Ar destroyed and docinstruct to re-attem Facility policy Charincluded "When a stresident's physical, status is identified there is need to altolicensed nursing as attending provider resident/resident resident/resident/resident/resident/resident/resident/resident/resident/resident/resid	ning daily weights in the eakfast, using the same scale. It in order for the resident to treatments nursing had to be essing for changes in weight, swelling. It is cocol for fluid management and received. Inge in Condition dated 2/2019, significant change in the mental, or psychosocial by the licensed nurse, or when the treatment significantly, the esociate consults with the eart not received. The policy did ne what constitutes a change estocol for bowel management and received. Inistering Medications 2/2019, ister resident medications in a manner that will ensure the 6 in administration. Medications in accordance with the orders. In administration with the orders. In administered within their management and as a refusal (did not possible in Condition dated 2/2019, significant change in the mental, or psychosocial by the licensed nurse, or when the treatment significantly, the esociate consults with the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	SUGGESTED MET DON could do qual focusing on resider respiratory condition diagnosis in order to concerns. The DON conditions that required The DON could the training/competence. The DON could devauditing system as assurance program compliance. TIME PERIOD FOR (21) days.	HOD OF CORRECTION: The ity of care chart audits ats with acute conditions, and, constipation, and cardiac o identify any potentia of could review protocals for aire monitoring/assessment. In develop and implement of any programs to nursing staff. It is velop and implement an part of the facility's quality of the monitor for ongoing a CORRECTION: Twenty-one	2 830			
2 885	Nursing Care; Programmust have an active nursing care directed resident to achieve practicable physical well-being according resident assessment in parts 4658.0400 efforts must be made and purposeful act. This MN Requirement by: Based on interview facility failed to ensident the services to meet the	m required. A nursing home e program of rehabilitation ed toward assisting each and maintain the highest I, mental, and psychosocial g to the comprehensive and plan of care described and 4658.0405. Continuous de to encourage ambulation ivities. ent is not met as evidenced and document review, the ure staff provided restorative e assessed needs for 3 of 3 2, R13) reviewed for	2 885	Corrected		12/4/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE COMP	SURVEY LETED
	00419	B. WING		10/2) 3/2020
PROVIDER OR SUPPLIER				10/2	0/2020
A TOWERS OF ROC	HESTER INC 4001 19TH	AVENUE N	ORTHWEST		
	ROCHES	1		211	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 39	2 885			
Findings include:					
diagnoses of ataxia coordination) and disystem (loss of function system (loss of function system (loss of function system). R13's quarterly Minassessment dated cognitively intact, his vision, clear speech clear comprehensic assistance of one stoileting, and locom Walking in her room once or twice.	i (impaired balance or legeneration of nervous ction or structure of nerves of simum 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.				
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 restorations walking. The report zero times between times, the report lis Other reasons inclusives, deferred duand unknown.	20 indicated R13 required to address neuromyopathy and degenerative disease of with decreased mobility. The indicated R13 would the 150 feet daily and use the bicycle) 10 minutes daily and 2:15 p.m. Thistory report indicated the active nursing related to indicated R13 ambulated in 9/21/20 and 10/22/20. Three ted the reason as "refused." Inded: not observed, could not use to condition, unavailable				
	PROVIDER OR SUPPLIER NA TOWERS OF ROC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Findings include: R13 R13's face sheet, p diagnoses of ataxia coordination) and d system (loss of funct the spinal cord). R13's quarterly Min assessment dated cognitively intact, h vision, clear speech clear comprehensic assistance of one s toileting, and locom Walking in her room once or twice. R13's care plan cat 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. R13's point of care frequency of restors walking. The report zero times between times, the report lis Other reasons inclu assess, deferred du and unknown.	OF CORRECTION O0419 PROVIDER OR SUPPLIER NA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 Findings include: R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination) and degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers, toileting, and locomotion on and off the unit. Walking in her room or corridor occurred only once or twice. R13's care plan category called restorative nursing dated 3/25/20 indicated R13 required restorative program to address neuromyopathy (disease of nerves) and degenerative disease of the nervous system with decreased mobility. Goals and approaches indicated R13 would continue to ambulate 150 feet daily and use the NuStep (stationary bicycle) 10 minutes daily between 6:00 a.m. and 2:15 p.m. R13's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R13 ambulated zero times between 9/21/20 and 10/22/20. Three times, the report listed the reason as "refused." Other reasons included: not observed, could not assess, deferred due to condition, unavailable	OPPONIDER OR SUPPLIER STREET ADDRESS, CITY, S 4001 19TH AVENUE N ROCHESTER, MN 583 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 Findings include: R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination) and degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers, toileting, and locomotion on and off the unit. Walking in her room or corridor occurred only once or twice. 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OPPOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, IM 55901 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 Findings include: R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination) and degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers, toileting, and locomotion on and off the unit. Walking in her room or corridor occurred only once or twice. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	was able to use the but now that they we happening. R13 state if she wanted to R13 admitted she sto 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 most bottom line then the was not able to tell services had affect that it may eventual R12 R12's facesheet, proceeding the proceeding movement debility, osteoporos brittle), muscle wear R12's quarterly Minassessment dated cognitively intact, himpaired vision requipments of two sand toileting, and recomprehension. R1 assistance of two sand toileting, and recomposition on the under the state of the same state of the same state of the same state of two sand toileting, and recomposition on the under the same state of the same stat	ley had a restorative aid, she is NuStep and walk in the hall, were short staffed, this was not ated only two staff have asked to 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 is R13 stated, "I'm paying a lot e and they aren't always "R13 stated this has been ent council, "but the new re concerned about the eresidents." R13 stated she if the lack of restorative ed her, but expressed concern lly "catch up." Intended 10/23/20, indicated ason's disease (disease t), age-related physical sis (bones become weak and alkness and repeated falls. Immum 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 unit.	2 885			
		20, indicated R12 required				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
						;
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	restorative program disease with muscl approaches indicat ability to ambulate a for 10 minutes daily p.m. R12's point of care frequency of restorwalking. The report feet daily during the seven times between only one time did si report listed the reareasons included: rassess, deferred duand unknown. During an interview R12 stated, "If they doing good, and I devery day and I'm rate. I'm not active not using the NuSte "They didn't renew no one to sit with ye she would like to withat in the morning could walk and staff comes." R11 R11's facesheet, pridiagnosis of demer debility, osteoarthriand muscle weakner.	n to address Parkinson's e weakness. Goals and ed R12 would maintain the 200 feet daily and ride NuStep 7, between 6:00 a.m. and 2:15 history report indicated the ative nursing related to 1 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 on 10/22/20, at 1:31 p.m. walk me once a week, I'm 10 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 f say, "Later, but later never inted 10/23/20, indicated atia, age related physical tis (wearing down of bones) ess.	2 885			
	assessment dated	8/11/20 indicated R11 had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00440	B. WING		40/0	
		00419			10/2	3/2020
NAME OF PE	ROVIDER OR SUPPLIER			ORTHWEST		
MADONNA	A TOWERS OF ROC	HESTER INC	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
	hearing and vision, understood and had required extensive mobility, transfers, fand off the unit. R1 of one when walkin the corridor with as twice. During an interview R11 stated she war have time." R11 stated she could not helped her walk. R11's care plan cat nursing dated 3/25/restorative program (weakness, numbred damage), osteoarth fibromyalgia (wide sidecreased mobility indicated R11 would feet daily and use the between 6:00 a.m. R11's point of care frequency of restora walking. The report zero times between reasons included: rassess, deferred dand unknown. During a telephone p.m. family membedoing very well. FM	impairment, had adequate clear speech, was diclear 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 on 10/22/20, at 1:52 p.m., and to walk, "but staff don't atted, "I'm losing strength." R11 of recall the last time staff egory called restorative (20, indicated R11 required a to address neuromyopthay less and pain from nerve writis of both knees, and spread muscle pain) with a Goals and approaches dicontinue to ambulate 400 the NuStep 10 minutes daily	2 885			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00419	B. WING		10/2	; 3/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOWERS OF ROCHESTER INC			I 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 885	everyone else and could not confirm if doubt it, but I just d "They're overwheln don't know what's had nursing assistant (New worked without take much work to get donly two aids to cal had 15 residents by stated things that d staff included: dirty walking, toileting. "It's stressfulI go had things I couldn't do able to provide rest who require it, such know it's not getting staff or the time to restorative services stated, "They'll decithem." During an interview NA-C stated she had residents who are of stated "something I NA-C acknowledge were important for balance and streng brought this to the about that position rursing assistants are restorative services restorativ	they don't have time." "FM-E R11 walked daily stating, "I on't know." FM-E stated, ned and sympathetic, but I	2 885			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1101 12.11	or correction.	BENTH TO THOUTHOUSE IT.	A. BUILDING:			
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		ORTHWEST		
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	Continued From pa	ge 44	2 885			
	restorative services did not require special training because this was something taught in NA courses.					
	DON stated she had assistants to complit in the electronic moving onto the newas important so the care history report a some nursing assist documenting these medical record). Dochallenges of the farecognized that car restorative serves where stated she did not hear to determine being done according to the stated when she as restorative serves where the stated when	on 10/21/20, at 11:09 a.m. d been instructing nursing lete a task and then document medical record (EMR) before xt task. DON explained this hat these tasks show up in the last being done. DON stated stants have been resistant to tasks in the EMR (electronic DN acknowledged the staffing acility and stated she lete plan interventions, such as were not being done. DON have time to look at resident leter if restorative services were leng to the care plans. DON sked staff about whether were being done, some said they were doing it, some leter the todo it, and some said ment it. DON stated it was the ovided services as indicated acknowledged there wasn't t.				
	corporate vice pres stated, "In this indu challenged, we are to meet the needs of stated there was a and stated, "It's unfallowed to go." VPC meet resident need	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 its, was a combination of short disting staff was working,				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00419	B. WING		1 0/2	; 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	IA TOWERS OF ROC	HESTER INC	I AVENUE N ER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	providing guidance reported they did now who are on a restorate too busy, VPO-of some issues untited. Administrator adde the facility with Cowstaff quitting, and trestaff some pretty go concerns were more facility policy titled 2017, indicated: Purpose: To ensure comprehensively as restorative needs. 1. Restorative progeach resident can aphysical, mental and Restorative nursing highest level of indicated including daily living and bed mobility. 2. A registered nursing highest level of indicated including daily living and bed mobility. 3. A registered nursing and bed mobility. 4. A registered nursing incompliance investigation with podirector of nursing of the care plan to incompliance.	needed to be on the floor and "When informed staff of 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 cod ratios" and resident care re related to staff inefficiencies. Restorative Program dated residents are residents are resessed / reassessed for rams were established so that attain and maintain highest ad psychosocial well-being. If care promotes resident's rependence in activities reg, range of motion, ambulation residents will provide oversight to the the restorative interventions	2 885			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
74101041	or correction.	BENTIL TO A TOTAL TO MISELA.	A. BUILDING:			
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	Continued From pa	ge 46	2 885			
	(21) days.					
2 945	5 MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel		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 de reported to the nurs resident's care duri observation of a de	g personnel. Nursing sermine that residents are scribed. Residents needing be promptly assisted upon and the assistance must be manner that maintains or ident's dignity and respect. Devices must be provided to sident's independence in fluid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent as 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 fon, interview and document ailed to ensure food items anner to accommodate known esidents (R5) who had a canuts, and history of on (a severe, potentially life reaction) to peanuts. This ediate jeopardy (IJ) situation is served food items which		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00419	B. WING			C 23/2020
	PROVIDER OR SUPPLIER	HESTER INC 4001 19	DDRESS, CITY, S FH AVENUE N STER, MN 55			
(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 SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 945	The IJ began on 10 allergy to nuts was peanut butter. Dieta dessert than what F card which listed ar administrator and dinformed of the IJ of facility implemented was removed on 10 non-compliance rerseverity of D, isolat potential for more thimmediate jeopardy. Findings include: R5's Face Sheet in heart disease and of R5's quarterly Minimassessment dated adequate hearing a was able to comprequestions for the broadelirium. R5 was in walking, dressing an R5's care plan for r 10/22/18, identified peanuts and cashed During an interview stated he recently repeanut butter and sepanuts. R5 stated recognized the peastated he had a "ligitation of the peastated he peastated he had a "ligitation of the peastated he	/5/20, when R5, with a known served a dessert containing ary staff served a different R5 ordered from the dietary a allergy to nuts. The irector of nursing (DON) were in 10/21/20 at 6:45 p.m. The discorrective action and the IJ //22/20 at 6:00 p.m. However, mained at the lower scope and ed, no actual harm, with nan 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 shend. R5 refused to answer ief interview for mental status signs and symptoms of dependent with bed mobility, and toileting. Jutritional status dated an allergy to nuts, specifically contains the status of the st				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00440	B. WING		С	
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	ER, 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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From page 48		2 945			
	could have died and damn right I was scared." R5 stated he didn't go to the hospital this time but added, "it took a good two days to get it out of my system."					
	6:07 p.m. registered R5 was anxious an bite of a peanut who reported to RN-B hoand when he tasted out. At 7:04 p.m. River received an order for figiven only if R5 was ymptoms of shorting astrointestinal synclosely and did not	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 enptoms. R5 was monitored develop signs or symptoms of and did not require				
	documented in the of R5's reaction to included: "Rt [residingested the desse Rt. has a documenhe had a small bite stomach. Rt. unable allergic reaction but ongue swelled upremained A x O x 4 and was able to an rash, difficulty breaswelling noted. VS normal limit) see cheloctor name] notifipt. to ER via [ambu	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 WNL (vital signs within nart. On call for [doctor name], ed and gave orders to send lance name] emergently. Pt's ified. Report called to [name				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00419	B. WING		10/2	, 3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC		ORTHWEST		
			TER, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 945	5 Continued From page 49		2 945			
	During an interview 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 occur. During an interview culinary services diresidents were give to fill out for the next allergies, their men their allergies, their men their allergies; CSD his allergy to peanuincident 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 not receive the coo CSD-A verified ther culinary staff to know items to ensure a refor which they were incident report had received food for w stated it would be 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 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 peanut butter. C-C did not				
	learn about this inc know.	ident, CSD-A stated he didn't				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	
		00440	B. WING		C 10/23/2020	
		00419			10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE ORTHWEST		
MADON	NA TOWERS OF ROC	HESTER INC	TER, MN 55			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ige 50	2 945			
	SW-A stated she he scotch-a-roo bar m leader meeting. SV person who discove incident report, add nursing."	on 10/21/20, at 11:03 a.m. eard about R5 receiving the ade with peanut butter at a <i>N</i> -A stated it was up to the ered the event to fill out an ling "in this case, it was on 10/21/20, at 11:09 a.m.				
	the director of nurs aware R5 received peanuts on 10/5/20 on duty that evenin and added, "I'm sur	ing (DON) stated she was not a dessert which contained b. The DON stated the nurse g RN-B, was an agency nurse rprised I wasn't notified." The buld follow up with RN-B.				
	lead cook (LC)-B si main kitchen of the containers to nursir provided a docume week 1, Thursday" of food items to ser document did not ir food items, LC-B st	on 10/21/20, at 6:35 p.m. tated all food was made in the facility and delivered in metaling care for distribution. LC-Bent displaying the menu for "fall which indicated the quantities and to nursing care. While the indicate ingredients for any tated nursing care was ermining resident allergies.				
	stood in the kitcher placed the entrees handed the plate to a tray and added or dessert items to ea food were delivered from the main kitch in steam wells. DAplated with plastic of	25 p.m. dietary aide (DA)-A at the steam table, as he onto individual plates and of an aide who set the plate on old food, beverages and ch tray. DA-A stated pans of dieto the nursing care kitchen en in steel containers and put the A stated desserts arrived over the top, in a tall enclosed -A stated staff looked at the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
, , , , , , , , , , , , , , , , , , , ,	or correction.	BERTH 10/ WOWNSER	A. BUILDING:			
		00419	B. WING		10/2	3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	H AVENUE N			
	OUNTAL DV OTA		TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 945	Continued From pa	nge 51	2 945			
	order to plate the for cards included name likes, dislikes and for	s paper menu and diet card in bood accurately. Resident diet ne, room number, allergies, ood preferences. DA-A ard indicated an allergy to peanuts.				
	10/5/20, when R5 r DA-A was unaware scotch-a-roo bars a looked like butterso went by the menu t	s working the evening of received the scotch-a-roo bar. In 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.				
	10/21/20, at approxaides (DA)-B, (DA)-did not know there scotch-a-roo bars. to articulate the diff between butterscot bars. The dietary aiwith them following further stated there prevent it from occureceive new training	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 ablesterence in appearance such 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.	i			
	CSD-A stated after "told staff not to cha CSD-A went on to s dessert that day an butterscotch bars, b scotch-a-roo bars.	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 ad it was supposed to be but it was changed to CSD-A verified scotch-a-roo ally served to residents in				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	
					С	
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N FER, MN 559	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 945	Continued From pa	ige 52	2 945			
	nursing care and when asked how staff would know they contained peanut butter, he verified "they wouldn't."					
	dated 2012 indicate A tray card (or apprifor each resident reculinary services deconforms to physic dislikes and individ resident are being. The culinary service providing an accura with diet conforming which contains the information, updates—Name (first are "Room number"—Room number—Diet exactly are "Beverage presuper of the contains the information of the contains the contains the contains the information of the contains the	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) r s physician ordered ference				
	The immediate jeop was removed on 10 could be verified the had implemented a residents were not were allergic. Staff pre-meal service he changes, a red dot bring attention to focards and food mediately.	pardy that began on 10/5/20, 0/22/20, at 6:00 p.m. when it rough observation the facility new process to ensure served food for which they were observed to conduct a auddle to review resident diet was added to diet cards to addlergies. Review of diet nus were followed by staff to to resident food allergies and				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
1					(
		00419	B. WING		10/2	3/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADONN	IA TOWERS OF ROC	HESTER INC	I AVENUE N TER, MN 559	ORTHWEST		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 945	Continued From pa	ige 53	2 945			
	preferences. During	g meal service, food items				
	which contained kn	own resident allergens were				
		staff to avoid serving them. In				
	addition, the facility conducted a verification of food allergies on diet cards against food allergies identified in the resident's electronic medical					
		tion on the meal tray , including utilization of diet				
	cards, began on 10	0/22/20, continuing for staff to				
	be conducted prior to the next scheduled shift					
	staff worked. A communication book for staff had been established to identify resident diet changes. Lastly, an audit was conducted by the					
		or designee, of diet cards to curately labeled for diet				
		allergens. Audit results were				
	reported to the qua	lity council.				
	SUGGESTED MET	THOD OF CORRECTION:				
		sing, or designee, could review				
		and procedures related to ing and provide staff				
		o the care of residents who				
	use require special	diets related to allergies. The				
		or designee could develop an				
		appropriate appropriate appropriate appropriate				
	promote resident in					
		R CORRECTION: Twenty-one				
	(21) days					
21520	MN Rule 4658.130	0 Subp. 1-4 Medications and	21520			12/4/20
	Pharmacy Services					

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		00419	B. WING		C 10/23/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	I AVENUE N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21520	Continued From pa	ge 54	21520			
	Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4.					
	means drugs with a have established m	II drugs. "Schedule II drugs" a high potential for abuse that nedical uses as defined in s, section 152.02, subdivision				
	services" means se acquiring, receiving	acy services. "Pharmacy ervices to ensure the accurate g, and administering of all needs of each resident.				
	Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking.					
	by: Based on interview facility failed to ens were available for a	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 6 8/4/2020, included	rovided by the facility on ed diagnoses of hepatic rhosis of liver, diabetes type to behavioral disturbance, and elimination care plan dated is taking lactulose; goal of 2-3 per day due to cirrhosis.				
	R1's physician order- Lactulose solution	ers included: 30 ml three times a day for				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00440		B. WING			C
		00419		D. WIITO		10/.	23/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC		H AVENUE N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21520	Continued From pa			21520			
	-Hydrocortisone 5 r tablets three times	milligrams (mg); adm a day (start date 8/1 ndroitin 500-400 mg	9/2020)				
	identified multiple d given related to the -8/4/2020, MAR- or	ministration record (loses of lactulose we medication not avaine dose was not adm	ere not lable.				
	administered: drug/ -8/6/2020, MAR - 2	of 3 doses were not litem unavailable. of 3 doses were not					
	-8/6/2020, MAR - 2 of 3 doses were not administered: drug/item unavailable8/30/2020, MAR - 2 of 3 doses not administered; drug/item unavailable9/15/2020, MAR - 1 of 3 doses not administered; drug/item unavailable9/27/2020, MAR - 2 of 3 doses not administered; drug/item unavailable.						
	Hydrocortisone -10/7/2020, MAR - administered: drug/	1 of 3 doses was no item unavailable	t				
	Glucosamine -Chro -8/22/2020, MAR- 2 administered: drug/	2 of 2 doses were no	t				
	10/23/2020, include hypertension, veno the liver, Chronic ki	rovided by the facility ed diagnoses of esseus insufficiency, cirrly dney disease stage insufficiency, and sension.	ential nosis of 3,				
	R9's physician orde	ers included:					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
AUDI 19TH AVENUE NORTHWEST ROCHESTER, IM 59901 CAJ D			00419		B. WING			-
CALID SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION PREFIX TAG	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21520 Continued From page 56 -Amitriptyline 2%-ketamine 5% -lidocaine 2% in lipoderm cream, apply to bilateral knees 1 gram topically two times a day (Start date 9/28/2020)Nystatin powder 100,000 unit/gram; one application four times a day (Start date 9/21/2020) -Hydrocortisone cream 2.5% Mix 1:1 with Ketoconazole and apply to the effected area twice a day (start date 9/21/2020), stop date 10/3/2020) R9's medication administration record (MAR) identified the medicated cream/ointments were not available to administer per physician orders. Amitriptyline cream Medication administration record (MAR) on 10/5/2020, medication was not administered; drug/item unavailable. Nystatin MAR 9/21/2020, 2 of 4 application not administered; pharmacy won't send and drug/item unavailable. MAR 9/22/2020, 4 of 4 applications not administered; drug/item unavailable. MAR 9/22/2020, 1 of 4 application not administered; drug/item unavailable. MAR 9/23/2020, 1 of 4 application not	MADON	NA TOWERS OF ROC	HESTER INC					
-Amitriptyline 2%-ketamine 5% -lidocaine 2% in lipoderm cream, apply to bilateral knees 1 gram topically two times a day (Start date 9/28/2020)Nystatin powder 100,000 unit/gram; one application four times a day (start date 9/21/2020) -Hydrocortisone cream 2.5% Mix 1:1 with Ketoconazole and apply to the effected area twice a day (start date 9/21/2020, stop date 10/3/2020) R9's medication administration record (MAR) identified the medicated cream/ointments were not available to administer per physician orders. Amitriptyline cream Medication administration record (MAR) on 10/5/2020, medication was not administered; drug/item unavailable. Nystatin MAR 9/21/2020, 2 of 4 application not administered; pharmacy won't send and drug/item unavailable. MAR 9/22/2020, 4 of 4 applications not administered; drug/item unavailable. MAR 9/23/2020, 1 of 4 application not	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLETE
administered; drug/item unavailable. MAR 9/28/2020, 2 of 4 applications not administered; drug/item unavailable Hydrocortisone cream MAR 9/21/2020, 2 of 2 applications not administered; drug/item unavailable new admit med unavailable, and pharmacy won't send. MAR 9/22, 9/23, 9/24, 9/25/2020, 2 of 2 applications were not administered; drug/item unavailable MAR 9/26/2020, 1 of 2 applications not	21520	-Amitriptyline 2%-klipoderm cream, aptopically two times -Nystatin powder 14 application four tim 9/21/2020) -Hydrocortisone creketoconazole and atwice a day (start d 10/3/2020) R9's medication adidentified the medication administered to adrawailable to	etamine 5% -lidocain ply to bilateral knees a day (Start date 9/20,000 unit/gram; ones a day (start date eam 2.5% Mix 1:1 wit apply to the effected ate 9/21/2020, stop of a stated cream/ointment in tration record (MAR) ion was not administration not macy won't send and ole. of 4 applications not item unavailable. of 4 applications not item unavailable in the macy won't send and ole. of 4 applications not item unavailable of 4 applications not item unavailable am of 2 applications not item unavailable newnd pharmacy won't send and ole am of 2 applications not item unavailable newnd pharmacy won't send administered; drug ot adminis	s 1 gram 8/2020). e th area date MAR) ts were n orders.	21520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
00419		B. WING		C 10/23/2020		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/2	0/2020
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N TER, MN 559	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 APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21520	administered; drug, MAR 9/27/2020, 1 administered; drug, MAR 9/30/2020, 1 administered; drug, MAR 10/2/2020, 1 administered; drug, MAR 10/2/2020, 1 administered; drug, During an interview trained medication was not to let the nurse know are supposed to or unawareness if it we error if the medicat pharmacy. During an interview director of nursing were not available considered a medication error recompleted, the phy notified, and the phy notified, and the phy notified are dications were own as a medication rijust give when the confirmed pharmacy available 24/7, how to communicate the immediately. PT standard medication; omis considered medication considered medication the physician; omis considered medication.	Vitem unavailable. of 2 applications not Vitem unavailable of 2 applications not Vitem unavailable. of 10/19/2020, at 9:37 a.m. assistant (TMA)-B stated if a t available then then supposed w; if it's not ordered then we der it. TMA-B indicated an ras considered a medication ion was not available from of 10/20/2020, at 11:16 a.m. (DON) indicated if medications for administration, it was reation error. The DON stated a port should have been armacy contacted. of 10/21/2020, at 2:35 p.m. chnician (PT) stated delivered to the facility, if there iot available then staff would medication was available. PT rey delivery services were rever facility staff would have an available the medication ated if the pharmacy did not in, facility staff should notify sion of medication was	21520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		С		
00419		B. WING		10/23/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	I AVENUE N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21520	medication was not medication error an notified. LPN-A indicontacted. LPN-A sidid not have the methe back-up pharmation of the back-up pharmation of the notified. DON stated if a medicated and a bashould be available are scheduled. During a return phosa transport of administration the notified of the notificated an expectifacility for administration expected to be notified available. NP-B index not available. The Accepting Delicated 9/2018, inclusive medication delicated 9/2018, inclusive medication delicated of the nurse notified of the nurse nurs	urse (LPN)-A stated if a tavailable it was considered and the nurse should be cated the pharmacy should be stated if the primary pharmacy edication then we would call	21520			
		of Correction: The signee could review the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED			
		00419		B. WING			C 23/2020	
		00413				107	23/2020	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MADONNA TOWERS OF ROCHESTER INC				I AVENUE N TER, MN 559	ORTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21520	pharmacy policy an the delivery of med Provide training for staff regarding thes	ge 59 Id revise systems to implications for each reside pharmacy staff and face systems and could movery system to assure	nt. ility	21520				
	TIME PERIOD FOR days	R CORRECTION: Thirt	y (30)					
21545	MN Rule 4658.1320	O A.B.C Medication Erro	ors	21545			12/4/20	
	percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refepurposes of this pa (1) a discrepal prescribed and what administered to reseption (2) the administered to reserve to a significant (1) an error of the discomfort or jeopal safety; or (2) medication usually requires the blood to be titrated single medication exprecipitate a reoccutoxicity. All medication prescribed. An incomplete the significant prescribed.	ast ensure that: on error rate is less than ed in the Interpretive e of Federal Regulation (m), found in Appendix as Manual, Guidance to -Term Care Facilities, we erence in part 4658.131 rt, a medication error m ncy between what was at medications are actual idents in the nursing host atration of expired any significant medication medication error is: which causes the reside rdizes the resident's he con from a category that a medication in the reside to a specific blood level error could alter that level error could alter that level error action of medication in the resident report or medication and ident report or medication and identification in the resident report or medication and identification in the resident report or medication and identification in the resident report or medication report report r	ns, title P of which is 5. For neans: ally ome; or on ent alth or dent's I and a el and as on					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		C	
00419		B. WING		10/23/2020		
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONNA TOW	ERS OF ROC	HESTER INC	H AVENUE N TER, MN 55	ORTHWEST 901		
	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
that oc resider physici resider design must b C. prescri error rethat oc resider physici resider design must b This M by: Based review, resider manag care in practici insulin notifica immed The im R1 req (low ble staff to status a administ preven of the I	ONNA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. This MN Requirement is not met as evidenced		21545	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
00419		B. WING		C 10/23/2020				
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE			
MADONI	NA TOWERS OF ROC	HESTER INC		I AVENUE N ER, MN 559	ORTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21545	Continued From pa	ge 61		21545				
	non-compliance remained at a lower scope and severity level of G, a pattern with actual harm but is not immediate jeopardy.							
	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 [li	ncluded diagnoses of ver] failure, alcoholic nentia without behavio	cirrhosis					
	R1's admission Minimum Data Set (MDS) assessment dated 8/7/20, indicated R1 had severe cognitive impairment, was independent with eating, and required insulin. MDS dated 8/24/20, indicated, R1 required one person physical assist and supervision for eating.							
	indicated R1 had ty insulin. R1 goals in	plan revised on 8/27/2 ope 1 diabetes that red ocluded, "Will have no elated to] diabetes and	quired					