DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 12, 2021

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

RE: CCN: 245153
Cycle Start Date: May 10, 2021

Dear Administrator:

On June 22, 2021, we notified you a remedy was imposed. On July 30, 2021 the Minnesota Department 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 July 6, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 7, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 22, 2021, 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 May 28, 2021. 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
Email: melissa.poepping@state.mn.us

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August 12, 2021

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

Re: Reinspection Results
Event ID: V70U12

Dear Administrator:

On July 30, 2021 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 May 28, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any 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
Email: melissa.poepping@state.mn.us

Electronically delivered

June 22, 2021

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

RE: CCN: 245153
Cycle Start Date: May 10, 2021

Dear Administrator:

On May 21, 2021, we informed you that we may impose enforcement remedies.

On May 28, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 27, 2021, the situation of immediate jeopardy to potential health and safety cited at F695 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(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 7, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 7, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 7, 2021.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 May 28, 2021. 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 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), 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 10, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates 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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	C 05/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/26/21 to 5/28/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5153050C (MN00073191 and MN00073187), with a deficiency cited at F580 and F695. The survey resulted in an Immediate Jeopardy (IJ) at F695 when the facility failed to report and replace necessary components of BIPAP machine to ensure adequate respiratory management. The IJ began on 5/20/21, and the immediacy was removed on 5/28/21, but non-compliance remained at the lower scope and severity of D- isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 5/28/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2021

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		7/6/21

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F 580	Continued From page 2 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify power of attorney/resident representative an essential respiratory device was not utilized per physician order and failed to notify of change in condition for 1 of 3 (R1) residents reviewed for respiratory management. Findings include During an interview on 5/26/21, R1's family member (FM)-B stated he went up to visit R1 on 5/23/21, between 7:30 a.m. and 8:00 a.m. FM-B stated, R1's BIPAP was not on, she had her oxygen on via nasal cannula however, one of the cannula's was not in her nose and the oxygen was only set to 2.0 L (liters) instead of 3. FM-B stated she did not look good and was barely responsive when he asked her questions. FM-B stated he got the nurse, and shortly thereafter, R1 was sent to the hospital via ambulance where	F 580	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. F580-Notification of Changes R1 is no longer in the facility All residents who reside at Madonna Towers have the potential to be affected. Licensed nursing staff will be reeducated on facility□s change of condition policy with emphasis on provider and responsible party notification.	

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F 580	Continued From page 3 she was in a coma in the intensive care unit. FM-B stated her prognosis was poor, and although he remained hopeful the doctors told him she would probably not survive. FM-B stated, R1 absolutely had to have her BIPAP on and was very faithful about using it because she had a history of polio that left her with severe pulmonary hypertension. FM-B stated R1 required 3.0 L of oxygen when the BIPAP was on and during the day she need 1.0-2.0 L of oxygen. FM-B stated the BIPAP machine R1 used at the facility was her own from home. FM-B stated he was not notified by the facility of any problems or issues with the BIPAP. R1's face sheet, identified R1 was admitted to the facility on 5/18/21 with diagnoses that included post-polio syndrome, restrictive lung disease, pulmonary hypertension due to lung diseases and hypoxia, obstructive sleep apnea, dyspnea, shortness of breath, presence of cardiac pacemaker, atrial fibrillation, and dependence on supplemental oxygen. R1's physician orders included: -Patient to wear BIPAP at night time with 3 L of oxygen twice per day 2:30 p.m. - 11:00 p.m., 11:00 p.m. - 6:00 a.m. (start date 5/18/21) -Patient may use 2L of oxygen as needed during activity (start date 5/18/21). R1's respiratory care plan dated 5/18/21, included: Uses oxygen related to chronic respiratory failure with hypoxia (did not identify diagnosis of hypercapnia), shortness of breath and uses BIPAP related to obstructive sleep apnea.	F 580	Event completion for notifications will be audited 5x / week for (3) weeks, and then twice weekly for an additional (3) weeks with EMR reporting function Facility Activity Report. Audit findings will be presented to facility s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 580	Continued From page 4	F 580		

R1's progress note dated 5/21/21, at 6:25 a.m. included, "Resident is missing a piece of her CPAP [sic], clip for mask to connect to head piece, unable to locate. 02 (oxygen) administered via nasal cannula at 3 L/min per overnight order."

R1's progress note on 5/21/21, at 9:50 p.m. indicated R1 did not have the BIPAP on because "strip on right side broken".

During an interview on 5/27/21, at 9:59 a.m. registered nurse (RN)-A stated she worked the overnight shifts on 5/21 and 5/22/21. RN-A stated R1 did not wear her BIPAP mask on 5/21 or 5/22 because the mask was broken so she applied the 3 L of oxygen via nasal cannula. RN-A stated during her shift on 5/22/21, R1 was really confused, RN-A assessed 02 [oxygen] saturation levels, it was 95%. RN-A stated she had obtained R1's 02 saturations a couple of times and they were stable at 95%. RN-A said since R1's O2 levels were fine, RN-A thought R1 must have a urinary tract infection. RN-A stated she did not document the vital signs or the new onset of the confusion and indicated she did not notify the physician or family member. RN-A indicated she had reported the broken BIPAP machine to RN-B either on the morning of the 5/21, or 5/22/21.

During an interview on 5/27/21, at 9:09 a.m. RN-B stated he worked the morning of 5/23/21. RN-B stated NA-B called him around 8:00 a.m. requesting he go to R1's room right away. RN-B stated he had not previously been in R1's room that morning. RN-B stated when he arrived to R1's room, R1 had not had her BIPAP on, but had on 3 L of oxygen per nasal cannula . RN-B indicated the BIPAP was not on because there

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F 580	Continued From page 5 was a piece missing. RN-B stated R1 was minimally responsive, only able to answer simple questions, and R1 was not able to report her symptoms. RN-B stated he took her vital signs and called the ambulance. RN-B indicated when he started his shift that morning nothing had been reported about R1. RN-B indicated he became aware of the BIPAP broken piece either on 5/21 or evening of 5/22/21. During an interview on 5/27/21, at 4:45 p.m. FM-B stated R1 remained in the intensive care unit (ICU), prognosis was unchanged. FM-B stated the facility had not notified him of the missing part of BIPAP mask, and indicated that could have been avoided, he could have obtained a part from their supplier or told them where to go to get one, "this is very unfortunate". During an interview on 5/27/21, at 9:47 a.m. director of nursing (DON) stated she was not aware R1 was missing a piece of her BIPAP mask and had not been used. DON stated staff should have notified the physician/family member and contacted a supplier for replacement parts. DON also indicated if BIPAP/CPAP's were not used related to missing parts/rejections it was an expectation respiratory status be monitored and documented. DON also indicated the physician/family member should have been notified of R1's new onset of confusion as it is a symptom of respiratory distress.	F 580		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		7/6/21

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

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F 695	Continued From page 6 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician ordered respiratory devices were functioning appropriately, notify the physician with a change in cognition and failed to monitor and identify signs/symptoms of respiratory distress for 2 of 3 residents (R1 and R2). The facility's failures resulted in an immediate jeopardy for R1 who suffered serious harm when she displayed respiratory distress, subsequently transferred to the hospital, and admitted to the intensive care unit. The facility's failures had the potential to effect addition 3 of 3 residents who continued to reside in the facility who required physician ordered respiratory devices. The immediate jeopardy began on 5/20/21, when the facility failed to report and replace necessary components of BIPAP (non-invasive ventilator that pushes air in and out of the lungs to help with breathing) machine to ensure adequate respiratory management and was identified on 5/27/21. The director of nursing (DON), administrator, and the director of nursing in training were notified of the immediate jeopardy at 2:25 p.m. on 5/27/21. The immediate jeopardy was removed on 5/28/21, but non-compliance remained at the lower scope and severity of D-isolated scope and severity level, which indicated no actual harm with potential for more than	F 695	F695-Respiratory Care R1 is no longer in facility. R2□s CPAP□s machine was checked and functioning properly and has since had a mask replacement. R2□s care plan was updated to reflect refusals of use of CPAP. Like residents include all individuals on BiPAP or CPAP residing at Madonna Towers of Rochester. All BiPAP/CPAP equipment was checked for proper functioning and no others have malfunctioning or broken equipment at this time. As part of the abatement plan, all licensed nursing staff received reeducation on the facility□s oxygen therapy policy with emphasis on provider and responsible party notification and abnormal findings following respiratory assessment. Unlicensed nursing received reeducation on hypoxia and to report confusion. All nursing staff received education on checking the functionality of CPAP/BiPAP equipment. All nursing staff were reeducated to notify the respiratory service and the DON/ED regarding malfunctioning or broken equipment. All	

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F 695	Continued From page 7 minimal harm that is not immediate jeopardy. Findings include: During an interview on 5/26/21, at 4:59 p.m., R1's family member (FM)-B stated he went up to visit R1 on 5/23/21, between 7:30 a.m. and 8:00 a.m. FM-B stated, R1's BIPAP was not on, she had her oxygen on via nasal cannula, however, one of the cannula's was not in her nose and the oxygen was only set to 2.0 L (liters) instead of 3. FM-B stated she did not look good and was barely responsive when he asked her questions. FM-B stated he got the nurse, and shortly thereafter, R1 was sent to the hospital via ambulance where she was in a coma in the intensive care unit. FM-B stated her prognosis was poor. FM-B said he remained hopeful, but the doctors told him she would probably not survive. FM-B stated, R1 absolutely had to have her BIPAP on and was very faithful about using it because she had a history of polio that left her with severe pulmonary hypertension. FM-B stated R1 required 3.0 L of oxygen when the BIPAP was on and during the day she required 1.0-2.0 L of oxygen. FM-B stated the BIPAP machine R1 used at the facility was her own from home. FM-B stated he was not notified by the facility of any problems or issues with the BIPAP including missing parts. R1's hospital discharge summary dated 5/18/21, included diagnosis of chronic respiratory with hypercapnia and indicated the hypercapnia was related to the restrictive lung disease and obstructive sleep apnea. The discharge summary identified R1 required BIPAP to manage sleep apnea.	F 695	unlicensed nursing staff were reeducated to report any malfunctioning or broken equipment to the nurse. Any malfunctioning or broken equipment is to be called in to the respiratory service and additional signage was posted for numbers to call. To ensure ongoing compliance, O2 sats and respiratory status will be audited 5x / week for (3) weeks, and then twice weekly for an additional 3 weeks. Audit findings will be presented to facility□s quality council by DON or designee. All residents are currently on covid monitoring including vitals with sats and respiratory monitoring. Licensed nursing staff received education on sign/symptoms of abnormal respiratory assessment finding(s). Unlicensed nursing staff were educated on s/s of hypoxia and abnormal confusion. Education was provided to associates in document form starting 05/27/2021 or before their next scheduled shift. All nursing staff will be educated in document form with competency verification by way of knowledge assessment starting 05/27/2021 or before their next scheduled shift. Symptom recognition will be audited 5x / week for (3) weeks, and then twice weekly for an additional (3) weeks with EMR reporting function □ Facility Activity Report. CPAP/BiPap equipment functionality will be audited 5x/week for	

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F 695	Continued From page 8 R1's admission Minimum Data Set (MDS) assessment dated 5/23/21, indicated R1 did not have signs and symptoms of delirium or rejection of care behaviors. The MDS identified R1 required extensive physical assist from one staff member for bed mobility, transfers, and toilet use. R1's progress note dated 5/18/21, indicated R1 was alert and orientated to person, place, and time. R1's face sheet, identified R1 was admitted to the facility on 5/18/21, with diagnoses of post-polio syndrome, restrictive lung disease, pulmonary hypertension due to lung diseases and hypoxia, obstructive sleep apnea, dyspnea, shortness of breath, presence of cardiac pacemaker, atrial fibrillation, and dependence on supplemental oxygen. R1's physician orders included: -Patient to wear BIPAP at night time with 3 L of oxygen twice[while sleeping] per day 2:30 p.m. - 11:00 p.m., 11:00 p.m. - 6:00 a.m. (start date 5/18/21) -Patient may use 2L of oxygen as needed during activity (start date 5/18/21). R1's respiratory care plan dated 5/18/21, included: Uses oxygen related to chronic respiratory failure with hypoxia (did not identify diagnosis of hypercapnia), shortness of breath and uses BIPAP related to obstructive sleep apnea. R1's goal indicated R1 would not have signs/symptoms of respiratory distress and	F 695	(3) weeks, and then twice weekly for an additional (3) weeks with the order audit function. Audit findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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saturations will be maintained within prescribed parameters. Interventions included, 1) oxygen saturations as ordered. Follow up with concerns. 2) oxygen settings as ordered. 3) BIPAP/CPAP (is a treatment method for patients who have sleep apnea) as ordered, 4) complete respiratory observations in Matrix (electronic health record) and summary in progress notes of findings. Update care plan to reflect interventions utilized to decrease symptoms of shortness of breath. 5) oxygen bleed [oxygen supply tube is attached to the BIPAP machine] as ordered. 6) observe/document/report: mental status changes, cyanosis, excessive paleness, shortness of breath, or level of consciousness, check oxygen saturation. Notify physician for concerns.

R1's Progress Notes from 5/21/21 to 5/23/21 revealed the following:

-5/21/21, at 6:25 a.m. "Resident is missing a piece of her CPAP [sic], clip for mask to connect to head piece, unable to locate. 02 (oxygen) administered via nasal cannula at 3 L/min per overnight order."

R1's record lacked evidence the physician was notified R1 had not used her BIPAP and or evidence the facility had obtained a replacement part.

-5/21/21, at 9:50 p.m. indicated R1 did not have the BIPAP on because "strip on right side broken." Although R1's treatment administration record (TAR) identified registered nurse (RN)-A checked the box indicating the BIPAP was on R1.

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-5/23/21, at 11:38 a.m. "Resident was found to be mostly unresponsive this am by CNA [certified nursing assistant] and nurse was alerted. When I arrived at the resident's bedside, she appeared to be in respiratory distress with labored breathing and gasping. Resident was on 3 L 02 via NC [nasal cannula]. Vitals were taken (see eMAR [electronic medication administration record]) and it was discovered that 02 sats were in the 80's. Writer determined that EMS [emergency medical system] should be called and resident was taken by ambulance to [name of hospital] for further care."

During an interview on 5/27/21, at 9:09 a.m. RN-B stated he worked the morning of 5/23/21. RN-B stated NA-B called him around 8:00 a.m. requesting he go to R1's room right away. RN-B stated he had not previously been in R1's room that morning. RN-B stated when he arrived to R1's room, R1 had not had her BIPAP on and only 3 L of oxygen. RN-B indicated the BIPAP was not on because there was a piece missing. RN-B stated R1 was minimally responsive, only able to answer simple questions, and R1 was not able to report her symptoms. RN-B stated he took her vital signs and called the ambulance. RN-B indicated when he started his shift that morning nothing had been reported about R1. RN-B indicated he became aware of the BIPAP broken piece either on 5/21 or evening of 5/22/21.

During an interview on 5/27/21, at 9:21 a.m. NA-B stated she had worked the morning of 5/23/21. NA-B stated FM-B had arrived at the facility between 7:30 a.m. and 8:00 a.m. NA-B stated FM-B notified her that R1 needed to be

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checked. NA-B stated she went into R1's room, R1 did not have her BIPAP on, 3 L of oxygen was on, and she called for RN-B using her walkie talkie. NA-B stated she had not been in R1's room prior.

During an interview on 5/27/21, at 9:47 a.m. director of nursing (DON) stated she was not aware R1 was missing a piece to her BIPAP mask and had not been used. DON stated staff should have notified the physician and contacted a supplier for replacement parts. DON also indicated if BIPAP/CPAP's were not used related to missing parts/rejections it was an expectation respiratory status be monitored and documented. DON also indicated the physician should have been notified of R1's new onset of confusion as it is a symptom of respiratory distress. DON stated staff had not been provided with education pertaining to CPAP/BIPAP machines within the last year.

During an interview on 5/27/21, at 9:59 a.m. RN-A stated she worked the overnight shifts on 5/21 and 5/22/21. RN-A stated R1 did not wear her BIPAP mask on 5/21 or 5/22/21, because the mask was broken so she applied the 3 L of oxygen via nasal cannula. RN-A verified the documentation on the TAR was incorrect. RN-A stated during her shift on 5/22/21, R1 was really confused, she had thought it maybe was because of low 02 saturations, although R1's levels were 95%. RN-A stated she had obtained R1's 02 saturations a couple of times and they were stable at 95%; RN-A stated since R1's oxygen saturations were good, she thought that R1 must have a urinary tract infection. RN-A stated she did not document the vital signs or the

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new onset of the confusion and indicated she did not notify the physician. RN-A indicated she had reported the broken BIPAP machine to RN-B but could not recall if it was the morning of the 5/21/21 or 5/22/21.

R1's record lacked evidence the physician was notified of the new onset of confusion and documentation of the change in cognition as well as the vital signs were not documented by RN-A.

During an interview on 5/27/21, at 10:09 a.m. certified nurse practitioner (CNP) indicated if a resident did not have their BIPAP on, hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) could occur and confusion. CNP stated R1 had sleep apnea so that is why she was on BIPAP at night, without the BIPAP she became hypoxic, this would affect her mental status and lead to decreased respiratory drive.

During an interview on 5/27/21, at 11:50 a.m. sleep medicine registered nurse (SM-RN) said the indication for R1's BIPAP use was for chronic respiratory failure with hypercapnia. SM-RN stated R1 had an overnight oximetry in February 2021, oximetry was good so no changes were needed to the therapy. SM-RN stated there had been no communications since February. SM-RN stated it would be very much concerning if R1 was not wearing the BIPAP for 2 nights, and if R1 was not able to wear the BIPAP because it was broken or missing pieces, the expectation would be to get it fixed or get a loaner. SM-RN stated R1 should be wearing the device whenever she was sleeping (daytime hours included), in general if patients sleep longer than 30 minutes

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F 695	Continued From page 13 they should use the devices however, was dependent upon on respiratory condition. Review of R1's vital signs included: -On 5/20/21, R1's record lacked respiratory monitoring between 9:08 p.m. and 6:22 a.m. when at 6:22 a.m. R1's oxygen saturations were 96% on 3.0 L of oxygen. -On 5/21/21, respiratory status/vital signs were not recorded after 5:50 p.m. -On 5/22/21, respiratory status/vital signs were not recorded after 5:06 p.m. -On 5/23/21, at 9:10 a.m. R1's oxygen saturations were 86% on room air, pulse was 108/per minute, blood pressure was 89/65. Respirations were not recorded. Review of R1's Point of Care History (record of encounters that identified when assistance/cares were provided to a resident) identified and indicated staff had not assisted R1 with any activities of daily living after 5/22/21, at 11:36 a.m. During a follow up interview on 5/27/21, at 4:45 p.m. FM-B stated R1 remained in the intensive care unit (ICU), prognosis was unchanged. FM-B stated the facility had not notified him of the missing part of BIPAP mask, and indicated that could have been avoided, he could have obtained a part from their supplier or told them where to go to get one, "this is very unfortunate". R2 During the following observation times on 5/26/21, at 9:07 p.m., 9:20 p.m., 9:35 p.m., 9:45 p.m. R2 laid in bed with his eyes closed, mouth	F 695		

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open, shallow respirations with short periods of apnea. R2's had a CPAP mask on the bedside table next to him and was not in use.

During an observation on 5/26/21, at 9:56 p.m. R2's contined to be laying in bed and CPAP mask remained on the bedside table and not in use. Nursing assistant (NA)-C was asked why R2 did not have his CPAP on, NA-C stated because he refused. NA-C was then asked where the documentation could be located and if the nurse had been made aware. NA-C then walked into R2's room, asked R2 if he wanted the CPAP on, R2 stated "no". NA-C was observed reporting to RN-C, R2 had refused his CPAP, RN-C asked NA-C, "why, did he refuse?" NA-C stated "he's refusing just like always." RN-C was observed to walk to R2's room and asked R2 why he didn't want to use his CPAP. R2 told RN-C he wasn't going to wear it. RN-C then told R2 he had been refusing his CPAP. R2 raised his voice and yelled he hasn't been refusing it, R2 indicated there was something wrong with it, he had told somebody, and nothing has been done about it.

R2's Face Sheet, included diagnoses of obstructive sleep apnea, congestive heart failure, and mild cognitive impairment.

R2's quarterly Minimum Data Set (MDS) assessment dated 3/2/2021, indicated R2 had severe cognitive impairment and required extensive assistance from one staff for dressing and personal hygiene.

R2's physician's orders included instruction on CPAP mask and reservoir cleaning/disinfecting (start date 4/26/21), however did not identify an

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F 695	Continued From page 15 order for the use of the CPAP. R2's care plan did not identify a plan of care for R2's obstructive sleep apnea and/or respiratory management. R2's progress note dated 4/22/21, included "Resident experiencing an episode of shortness of breath at the time of during night shift. Oxygen saturations at 88% on room air at the time." The note indicated a narcotic pain medication and oxygen were administered per standing orders; R2's oxygen saturations then increased to 94% on 2 L. R2's progress note dated 4/23/21, indicted follow up was done regarding shortness of breath and low oxygen saturations. R2's lung sounds were diminished at both lung bases and had wheezing, nurse practitioner was notified. R2's progress note dated 4/26/21, included, "New orders received: OK for CPAP use". During an interview on 5/26/21, at 10:00 p.m. RN-C stated he had remembered hearing there was something wrong with R2's CPAP but could not recall what it was. RN-C reviewed R2's physician orders and confirmed the order for CPAP was not transcribed into physician orders; record lacked documentation the CPAP was applied, and stated R2's record lacked documentation of R2's refusals to wear the CPAP. During an interview on 5/26/21, at 10:09 p.m. licensed practical nurse (LPN)-A indicated she was contracted to work at the facility through a	F 695		

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staffing agency. LPN-A stated she had been assigned to work on the unit R2 resided on. When asked if she was aware of any concerns and/or rejections pertaining to R2's CPAP machine, LPN-A stated she didn't work here and didn't know anything about it. LPN-A stated she did not go around and check if residents had their CPAP/BIPAP machines on, and stated an unawareness of who was monitoring the application/usage. LPN-A was asked what she was going do with the knowledge R2 had refused his CPAP, LPN-A stated she was going to notify the physician.

During an interview on 5/26/21, at 10:20 p.m. RN-D stated he was being trained as the new director of nursing (DON). RN-D stated if R2 refused to wear his CPAP it should be reported to the nurse and documented. RN-D stated if residents did not wear their CPAP/BIPAP as prescribed the physician should be notified and respiratory status should be monitored during the night.

During an interview on 5/27/21, at 10:56 a.m. family member (FM)-A stated R2's CPAP was purchased within the last 2 years and he used it at bedtime. FM-A stated shortly after R2 was admitted to the facility in December 2020, the facility called and told her they did not think he needed it, however they called within the last few months and told her to bring it up to the facility. FM-A stated she was not aware if the physician had discontinued the CPAP or how it was determined R2 did not need it. FM-A stated she had not been notified that there had been anything wrong with the CPAP or that R2 had not been wearing it. FM-A stated she was aware R2

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F 695	Continued From page 17 did not like wearing it, but he would wear it anyway. During an interview on 5/27/21, at 9:47 a.m. director of nursing (DON) was not aware that something was wrong with R2's CPAP. DON stated if there was something wrong, the supplier should have been notified and necessary part obtained. An undated facility policy Oxygen Therapy did not address procedures for malfunctioning or broken respiratory devices/equipment. The policy included: Oxygen therapy is provided to residents in a safe manner as identified by prescribed provider. Residents are assessed to ensure their respiratory needs are being met. Residents identified in need of oxygen therapy have interventions/equipment implemented in accordance with the resident-centered care plan. 6) document assessment of resident oxygen status, tolerance, vital signs, and respiratory status in medical record as necessary. 7) Follow manufacturer recommendations for safe handling, cleaning, humidification, storage, and dispensing, maintenance of equipment in accordance with manufacturer specifications and consistent with federal, state, and local laws and regulations. The immediate jeopardy that began on 5/20/21 was removed on 5/28/21, when the facility completed the following: A) Licensed nursing staff were reeducated on facility's oxygen therapy policy with emphasis on provider and responsible party notification of abnormal findings following respiratory assessments.	F 695		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 18 B) Licensed nursing staff were educated on sign/symptoms of abnormal respiratory assessment findings. C) All nursing staff were educated on checking functionality of CPAP/BIPAP equipment and notification procedures of malfunctioning or broken equipment. D) An auditing system was developed and implemented for identifying signs/symptoms of respiratory distress and CPAP/BIPAP functionality.	F 695		

Electronically delivered
June 22, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: V70U11

Dear Administrator:

The above facility was surveyed on May 26, 2021 through May 28, 2021 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	C 05/28/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/26/21 to 5/28/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will	2 000		

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: H5153050C (MN00073187 and MN00073191) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The	2 000		

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2 000	Continued From page 2 facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician ordered respiratory devices were functioning appropriately, notify the physician with a change in cognition and failed to monitor and identify signs/symptoms of respiratory distress for 2 of 3 residents (R1 and R2). The facility's failures resulted in an immediate jeopardy for R1 who suffered serious harm when she displayed	2 830	Corrected.	7/6/21

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2 830	Continued From page 3 respiratory distress, subsequently transferred to the hospital, and admitted to the intensive care unit. The facility's failures had the potential to effect addition 3 of 3 residents who continued to reside in the facility who required physician ordered respiratory devices. The immediate jeopardy began on 5/20/21, when the facility failed to report and replace necessary components of BIPAP (non-invasive ventilator that pushes air in and out of the lungs to help with breathing) machine to ensure adequate respiratory management and was identified on 5/27/21. The director of nursing (DON), administrator, and the director of nursing in training were notified of the immediate jeopardy at 2:25 p.m. on 5/27/21. The immediate jeopardy was removed on 5/28/21, but non-compliance remained at the lower scope and severity of D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview on 5/26/21, at 4:59 p.m., R1's family member (FM)-B stated he went up to visit R1 on 5/23/21, between 7:30 a.m. and 8:00 a.m. FM-B stated, R1's BIPAP was not on, she had her oxygen on via nasal cannula, however, one of the cannula's was not in her nose and the oxygen was only set to 2.0 L (liters) instead of 3. FM-B stated she did not look good and was barely responsive when he asked her questions. FM-B stated he got the nurse, and shortly thereafter, R1 was sent to the hospital via ambulance where she was in a coma in the intensive care unit. FM-B stated her prognosis was poor. FM-B said he remained hopeful, but	2 830		

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2 830	Continued From page 4 the doctors told him she would probably not survive. FM-B stated, R1 absolutely had to have her BIPAP on and was very faithful about using it because she had a history of polio that left her with severe pulmonary hypertension. FM-B stated R1 required 3.0 L of oxygen when the BIPAP was on and during the day she required 1.0-2.0 L of oxygen. FM-B stated the BIPAP machine R1 used at the facility was her own from home. FM-B stated he was not notified by the facility of any problems or issues with the BIPAP including missing parts. R1's hospital discharge summary dated 5/18/21, included diagnosis of chronic respiratory with hypercapnia and indicated the hypercapnia was related to the restrictive lung disease and obstructive sleep apnea. The discharge summary identified R1 required BIPAP to manage sleep apnea. R1's admission Minimum Data Set (MDS) assessment dated 5/23/21, indicated R1 did not have signs and symptoms of delirium or rejection of care behaviors. The MDS identified R1 required extensive physical assist from one staff member for bed mobility, transfers, and toilet use. R1's progress note dated 5/18/21, indicated R1 was alert and orientated to person, place, and time. R1's face sheet, identified R1 was admitted to the facility on 5/18/21, with diagnoses of post-polio syndrome, restrictive lung disease, pulmonary hypertension due to lung diseases and hypoxia, obstructive sleep apnea, dyspnea, shortness of breath, presence of cardiac pacemaker, atrial	2 830		

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2 830	Continued From page 5 fibrillation, and dependence on supplemental oxygen. R1's physician orders included: -Patient to wear BIPAP at night time with 3 L of oxygen twice[while sleeping] per day 2:30 p.m. - 11:00 p.m., 11:00 p.m. - 6:00 a.m. (start date 5/18/21) -Patient may use 2L of oxygen as needed during activity (start date 5/18/21). R1's respiratory care plan dated 5/18/21, included: Uses oxygen related to chronic respiratory failure with hypoxia (did not identify diagnosis of hypercapnia), shortness of breath and uses BIPAP related to obstructive sleep apnea. R1's goal indicated R1 would not have signs/symptoms of respiratory distress and saturations will be maintained within prescribed parameters. Interventions included, 1) oxygen saturations as ordered. Follow up with concerns. 2) oxygen settings as ordered. 3) BIPAP/CPAP (is a treatment method for patients who have sleep apnea) as ordered, 4) complete respiratory observations in Matrix (electronic health record) and summary in progress notes of findings. Update care plan to reflect interventions utilized to decrease symptoms of shortness of breath. 5) oxygen bleed [oxygen supply tube is attached to the BIPAP machine] as ordered. 6) observe/document/report: mental status changes, cyanosis, excessive paleness, shortness of breath, or level of consciousness, check oxygen saturation. Notify physician for concerns. R1's Progress Notes from 5/21/21 to 5/23/21 revealed the following:	2 830		

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2 830	Continued From page 6 -5/21/21, at 6:25 a.m. "Resident is missing a piece of her CPAP [sic], clip for mask to connect to head piece, unable to locate. 02 (oxygen) administered via nasal cannula at 3 L/min per overnight order." R1's record lacked evidence the physician was notified R1 had not used her BIPAP and or evidence the facility had obtained a replacement part. -5/21/21, at 9:50 p.m. indicated R1 did not have the BIPAP on because "strip on right side broken." Although R1's treatment administration record (TAR) identified registered nurse (RN)-A checked the box indicating the BIPAP was on R1. -5/23/21, at 11:38 a.m. "Resident was found to be mostly unresponsive this am by CNA [certified nursing assistant] and nurse was alerted. When I arrived at the resident's bedside, she appeared to be in respiratory distress with labored breathing and gasping. Resident was on 3 L 02 via NC [nasal cannula]. Vitals were taken (see eMAR [electronic medication administration record]) and it was discovered that 02 sats were in the 80's. Writer determined that EMS [emergency medical system] should be called and resident was taken by ambulance to [name of hospital] for further care." During an interview on 5/27/21, at 9:09 a.m. RN-B stated he worked the morning of 5/23/21. RN-B stated NA-B called him around 8:00 a.m. requesting he go to R1's room right away. RN-B stated he had not previously been in R1's room that morning. RN-B stated when he arrived to R1's room, R1 had not had her BIPAP on and	2 830		

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2 830	Continued From page 7 only 3 L of oxygen. RN-B indicated the BIPAP was not on because there was a piece missing. RN-B stated R1 was minimally responsive, only able to answer simple questions, and R1 was not able to report her symptoms. RN-B stated he took her vital signs and called the ambulance. RN-B indicated when he started his shift that morning nothing had been reported about R1. RN-B indicated he became aware of the BIPAP broken piece either on 5/21 or evening of 5/22/21. During an interview on 5/27/21, at 9:21 a.m. NA-B stated she had worked the morning of 5/23/21. NA-B stated FM-B had arrived at the facility between 7:30 a.m. and 8:00 a.m. NA-B stated FM-B notified her that R1 needed to be checked. NA-B stated she went into R1's room, R1 did not have her BIPAP on, 3 L of oxygen was on, and she called for RN-B using her walkie talkie. NA-B stated she had not been in R1's room prior. During an interview on 5/27/21, at 9:47 a.m. director of nursing (DON) stated she was not aware R1 was missing a piece to her BIPAP mask and had not been used. DON stated staff should have notified the physician and contacted a supplier for replacement parts. DON also indicated if BIPAP/CPAP's were not used related to missing parts/rejections it was an expectation respiratory status be monitored and documented. DON also indicated the physician should have been notified of R1's new onset of confusion as it is a symptom of respiratory distress. DON stated staff had not been provided with education pertaining to CPAP/BIPAP machines within the last year.	2 830		

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2 830	Continued From page 8 During an interview on 5/27/21, at 9:59 a.m. RN-A stated she worked the overnight shifts on 5/21 and 5/22/21. RN-A stated R1 did not wear her BIPAP mask on 5/21 or 5/22/21, because the mask was broken so she applied the 3 L of oxygen via nasal cannula. RN-A verified the documentation on the TAR was incorrect. RN-A stated during her shift on 5/22/21, R1 was really confused, she had thought it maybe was because of low 02 saturations, although R1's levels were 95%. RN-A stated she had obtained R1's 02 saturations a couple of times and they were stable at 95%; RN-A stated since R1's oxygen saturations were good, she thought that R1 must have a urinary tract infection. RN-A stated she did not document the vital signs or the new onset of the confusion and indicated she did not notify the physician. RN-A indicated she had reported the broken BIPAP machine to RN-B but could not recall if it was the morning of the 5/21/21 or 5/22/21. R1's record lacked evidence the physician was notified of the new onset of confusion and documentation of the change in cognition as well as the vital signs were not documented by RN-A. During an interview on 5/27/21, at 10:09 a.m. certified nurse practitioner (CNP) indicated if a resident did not have their BIPAP on, hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) could occur and confusion. CNP stated R1 had sleep apnea so that is why she was on BIPAP at night, without the BIPAP she became hypoxic, this would affect her mental status and lead to decreased respiratory drive. During an interview on 5/27/21, at 11:50 a.m.	2 830		

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2 830	Continued From page 9 sleep medicine registered nurse (SM-RN) said the indication for R1's BIPAP use was for chronic respiratory failure with hypercapnia. SM-RN stated R1 had an overnight oximetry in February 2021, oximetry was good so no changes were needed to the therapy. SM-RN stated there had been no communications since February. SM-RN stated it would be very much concerning if R1 was not wearing the BIPAP for 2 nights, and if R1 was not able to wear the BIPAP because it was broken or missing pieces, the expectation would be to get it fixed or get a loaner. SM-RN stated R1 should be wearing the device whenever she was sleeping (daytime hours included), in general if patients sleep longer than 30 minutes they should use the devices however, was dependent upon on respiratory condition. Review of R1's vital signs included: -On 5/20/21, R1's record lacked respiratory monitoring between 9:08 p.m. and 6:22 a.m. when at 6:22 a.m. R1's oxygen saturations were 96% on 3.0 L of oxygen. -On 5/21/21, respiratory status/vital signs were not recorded after 5:50 p.m. -On 5/22/21, respiratory status/vital signs were not recorded after 5:06 p.m. -On 5/23/21, at 9:10 a.m. R1's oxygen saturations were 86% on room air, pulse was 108/per minute, blood pressure was 89/65. Respirations were not recorded. Review of R1's Point of Care History (record of encounters that identified when assistance/cares were provided to a resident) identified and indicated staff had not assisted R1 with any activities of daily living after 5/22/21, at 11:36 a.m.	2 830		

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2 830	Continued From page 10 During a follow up interview on 5/27/21, at 4:45 p.m. FM-B stated R1 remained in the intensive care unit (ICU), prognosis was unchanged. FM-B stated the facility had not notified him of the missing part of BIPAP mask, and indicated that could have been avoided, he could have obtained a part from their supplier or told them where to go to get one, "this is very unfortunate". R2 During the following observation times on 5/26/21, at 9:07 p.m., 9:20 p.m., 9:35 p.m., 9:45 p.m. R2 laid in bed with his eyes closed, mouth open, shallow respirations with short periods of apnea. R2's had a CPAP mask on the bedside table next to him and was not in use. During an observation on 5/26/21, at 9:56 p.m. R2's contined to be laying in bed and CPAP mask remained on the bedside table and not in use. Nursing assistant (NA)-C was asked why R2 did not have his CPAP on, NA-C stated because he refused. NA-C was then asked where the documentation could be located and if the nurse had been made aware. NA-C then walked into R2's room, asked R2 if he wanted the CPAP on, R2 stated "no". NA-C was observed reporting to RN-C, R2 had refused his CPAP, RN-C asked NA-C, "why, did he refuse?" NA-C stated "he's refusing just like always." RN-C was observed to walk to R2's room and asked R2 why he didn't want to use his CPAP. R2 told RN-C he wasn't going to wear it. RN-C then told R2 he had been refusing his CPAP. R2 raised his voice and yelled he hasn't been refusing it, R2 indicated there was something wrong with it, he had told somebody, and nothing has been done about it.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00419	A. BUILDING: _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 11 R2's Face Sheet, included diagnoses of obstructive sleep apnea, congestive heart failure, and mild cognitive impairment. R2's quarterly Minimum Data Set (MDS) assessment dated 3/2/2021, indicated R2 had severe cognitive impairment and required extensive assistance from one staff for dressing and personal hygiene. R2's physician's orders included instruction on CPAP mask and reservoir cleaning/disinfecting (start date 4/26/21), however did not identify an order for the use of the CPAP. R2's care plan did not identify a plan of care for R2's obstructive sleep apnea and/or respiratory management. R2's progress note dated 4/22/21, included "Resident experiencing an episode of shortness of breath at the time of during night shift. Oxygen saturations at 88% on room air at the time." The note indicated a narcotic pain medication and oxygen were administered per standing orders; R2's oxygen saturations then increased to 94% on 2 L. R2's progress note dated 4/23/21, indicted follow up was done regarding shortness of breath and low oxygen saturations. R2's lung sounds were diminished at both lung bases and had wheezing, nurse practitioner was notified. R2's progress note dated 4/26/21, included, "New orders received: OK for CPAP use". During an interview on 5/26/21, at 10:00 p.m. RN-C stated he had remembered hearing there	2 830		

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2 830	Continued From page 12 was something wrong with R2's CPAP but could not recall what it was. RN-C reviewed R2's physician orders and confirmed the order for CPAP was not transcribed into physician orders; record lacked documentation the CPAP was applied, and stated R2's record lacked documentation of R2's refusals to wear the CPAP. During an interview on 5/26/21, at 10:09 p.m. licensed practical nurse (LPN)-A indicated she was contracted to work at the facility through a staffing agency. LPN-A stated she had been assigned to work on the unit R2 resided on. When asked if she was aware of any concerns and/or rejections pertaining to R2's CPAP machine, LPN-A stated she didn't work here and didn't know anything about it. LPN-A stated she did not go around and check if residents had their CPAP/BIPAP machines on, and stated an unawareness of who was monitoring the application/usage. LPN-A was asked what she was going do with the knowledge R2 had refused his CPAP, LPN-A stated she was going to notify the physician. During an interview on 5/26/21, at 10:20 p.m. RN-D stated he was being trained as the new director of nursing (DON). RN-D stated if R2 refused to wear his CPAP it should be reported to the nurse and documented. RN-D stated if residents did not wear their CPAP/BIPAP as prescribed the physician should be notified and respiratory status should be monitored during the night. During an interview on 5/27/21, at 10:56 a.m. family member (FM)-A stated R2's CPAP was purchased within the last 2 years and he used it	2 830		

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2 830	Continued From page 13 at bedtime. FM-A stated shortly after R2 was admitted to the facility in December 2020, the facility called and told her they did not think he needed it, however they called within the last few months and told her to bring it up to the facility. FM-A stated she was not aware if the physician had discontinued the CPAP or how it was determined R2 did not need it. FM-A stated she had not been notified that there had been anything wrong with the CPAP or that R2 had not been wearing it. FM-A stated she was aware R2 did not like wearing it, but he would wear it anyway. During an interview on 5/27/21, at 9:47 a.m. director of nursing (DON) was not aware that something was wrong with R2's CPAP. DON stated if there was something wrong, the supplier should have been notified and necessary part obtained. An undated facility policy Oxygen Therapy did not address procedures for malfunctioning or broken respiratory devices/equipment. The policy included: Oxygen therapy is provided to residents in a safe manner as identified by prescribed provider. Residents are assessed to ensure their respiratory needs are being met. Residents identified in need of oxygen therapy have interventions/equipment implemented in accordance with the resident-centered care plan. 6) document assessment of resident oxygen status, tolerance, vital signs, and respiratory status in medical record as necessary. 7) Follow manufacturer recommendations for safe handling, cleaning, humidification, storage, and dispensing, maintenance of equipment in accordance with manufacturer specifications and consistent with federal, state, and local laws and	2 830		

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2 830	Continued From page 14 regulations. The immediate jeopardy that began on 5/20/21 was removed on 5/28/21, when the facility completed the following: A) Licensed nursing staff were reeducated on facility's oxygen therapy policy with emphasis on provider and responsible party notification of abnormal findings following respiratory assessments. B) Licensed nursing staff were educated on sign/symptoms of abnormal respiratory assessment findings. C) All nursing staff were educated on checking functionality of CPAP/BIPAP equipment and notification procedures of malfunctioning or broken equipment. D) An auditing system was developed and implemented for identifying signs/symptoms of respiratory distress and CPAP/BIPAP functionality. SUGGESTED METHOD OF CORRECTION: The director of nursing/designee could review/revise/develop policies and procedures respiratory devices used for airway management. The DON/designee could then develop and provide education and training of respiratory devices. The DON/designee could the develop and implement an auditing system as part of the facility's quality assurance program to assure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		