

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

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically delivered

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

M. Ping

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

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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

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

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 05/28/2021		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 4001 19TH AVENUE NORTHWES ROCHESTER, MN 55901		1 001	20,2021	
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F 000	survey was conductive was found to be Not requirements of 42 Requirements for L. The following composubstantial SUBSTANTIATED and MN00073187) F580 and F695. The survey resulte (IJ) at F695 when the replace necessary machine to ensure management. The immediacy was remon-compliance reseverity of D- isolal which indicated no more than minimal jeopardy. The above findings quality of care, and conducted on 5/28. The facility's plan of as your allegation of Departments accessignature is not recepage of the CMS-2	B/21, a standard abbreviated cted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, Long Term Care Facilities. Plaints were found to be: H5153050C (MN00073191), with a deficiency cited at din an Immediate Jeopardy the facility failed to report and components of BIPAP adequate respiratory IJ began on 5/20/21, and the moved on 5/28/21, but mained at the lower scope and ted scope and severity level, actual harm with potential for harm that is not immediate as constituted substandard dian extended survey was 1/21. Diff correction (POC) will serve of compliance upon the ptance. Penrolled in ePOC, your quired at the bottom of the first 2567 form. Your electronic POC will be used as	FO					
L ABORATOR)	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATI IRE	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.

PRINTED: 06/25/2021 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	
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		245153	B. WING			05/	28/2021
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Up an to reg	onsite revisit of y validate substant gulations has bee	acceptable electronic POC, your facility may be conducted ial compliance with the en attained.	FC				
F 580 NG SS=D CF §4 (i) col col res ph (B) me de sta cliii (C) a r tre col (D) res §4 (ii) (14 all is a ph (iii) res wh (A) as	otify of Changes (FR(s): 483.10(g)(183.10(g)(14) Notice A facility must impossible the results with the results in injury and ysician interventice) A significant charterioration in head tus in either life-inical complication) A need to alter the heed to discontinue the termination of the fast of the facility of this section pertinent information available and proysician. The facility must sident and the results in results of the facility must available and proysician. The facility must sident and the results of the facility must appear in root specified in §483.	Injury/Decline/Room, etc.) 14)(i)-(iv)(15) ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or hs); treatment significantly (that is, ue an existing form of liverse consequences, or to orm of treatment); or ansfer or discharge the cility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment	F 5	880			7/6/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		245153	B. WING _			28/2021
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901		
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F 580	State law or regular (e)(10) of this sectic (iv) The facility musupdate the address phone number of the representative(s). §483.10(g)(15) Admission to a combatic second that is a composite §483.5) must disclose its physical configurations that compart, and must spectroom changes betwounder §483.15(c)(9) This REQUIREMENT by: Based on interview facility failed to notify facility failed to notify representative and was not utilized pernotify of change in residents reviewed Findings include During an interview member (FM)-B stated, R1's BIPAP oxygen on via nasacannula's was not if was only set to 2.0 stated she did not be responsive when he stated he got the niterior in the stated in the second	tions as specified in paragraph on. It record and periodically (mailing and email) and he resident Inposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to ween its different locations	F 58	Preparation, submission and implementation of this Plan of C does not constitute an admission agreement with the facts and co in the statement of deficiencies. of Correction is prepared and exa means to continuously improve quality of care, to comply with all applicable state and federal regurequirements and it constitutes the facility is allegation of complianted F580-Notification of Changes R1 is no longer in the facility. All residents who reside at Made Towers have the potential to be Licensed nursing staff will be reconfacility is change of condition with emphasis on provider and responsible party notification.	n of, or nclusions This Plan ecuted as e the I ulatory he ce.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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F 580	she was in a coma FM-B stated her proalthough he remain him she would probe R1 absolutely had to very faithful about to history of polio that pulmonary hyperter required 3.0 L of ox and during the day FM-B stated the Bll facility was her own was not notified by issues with the BIP. R1's face sheet, ide facility on 5/18/21 vpost-polio syndrom pulmonary hyperter and hypoxia, obstrushortness of breath pacemaker, atrial fi supplemental oxygen twice per da 11:00 p.m 6:00 aPatient may use 21 activity (start date 5 R1's respiratory failure widiagnosis of hyperodices.	in the intensive care unit. Degnosis was poor, and Ded hopeful the doctors told Deably not survive. FM-B stated, Described a state of the property of the prop	F 580	Event completion for notifications audited 5x / week for (3) weeks, a twice weekly for an additional (3) with EMR reporting function Fa Activity Report. Audit findings will presented to facility s Quality Co DON or designee. Results of monitoring shall be rep the facility Quality Council meetin ongoing frequency and duration to determined through analysis and of results.	and then weeks cility be uncil by orted at g with p be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 580	R1's progress note included, "Resident CPAP [sic], clip for piece, unable to loo via nasal cannula a R1's progress note indicated R1 did no "strip on right side but the because the mask of 3 L of oxygen via naturing her shift on 8 confused, RN-A assevels, it was 95%. R1's 02 saturations were stable at 95% levels were fine, RN urinary tract infection document the vital sconfusion and indiction physician or family had reported the breither on the morning. RN-B stated NA-B requesting he go to stated he had not p that morning. RN-B R1's room, R1 had had on 3 L of oxygen.	dated 5/21/21, at 6:25 a.m. is missing a piece of her mask to connect to head rate. 02 (oxygen) administered t 3 L/min per overnight order." on 5/21/21, at 9:50 p.m. t have the BIPAP on because	F 5	80			

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		(X3) DATE SURVEY COMPLETED	
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	was a piece missing minimally responsive questions, and R1 visymptoms. RN-B stand called the ambine started his shift been reported about became aware of the continuous properties on 5/21 or evening. During an interview FM-B stated R1 remunit (ICU), prognos stated the facility has missing part of BIP could have been an obtained a part from where to go to get of the could have missing an interview director of nursing (aware R1 was missing aware R	g. RN-B stated R1 was ve, only able to answer simple was not able to report her tated he took her vital signs ulance. RN-B indicated when that morning nothing had at R1. RN-B indicated he he BIPAP broken piece either of 5/22/21. If on 5/27/21, at 4:45 p.m. mained in the intensive care is was unchanged. FM-B ad not notified him of the AP mask, and indicated that voided, he could have in their supplier or told them one, "this is very unfortunate". If on 5/27/21, at 9:47 a.m. If DON) stated she was not sing a piece of her BIPAP been used. DON stated staffed the physician/family member pplier for replacement parts. If BIPAP/CPAP's were not sing parts/rejections it was an tory status be monitored and also indicated the ember should have been vonset of confusion as it is a	F 58			7/6/21
33-0	§ 483.25(i) Respira tracheostomy care	tory care, including and tracheal suctioning. sure that a resident who				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 695	care and tracheal scare, consistent with practice, the comportance plan, the reside and 483.65 of this stand 483.6	care, including tracheostomy suctioning, is provided such the professional standards of rehensive person-centered lents' goals and preferences, subpart. NT is not met as evidenced tion, interview, and document railed to ensure physician devices were functioning the physician with a change iled to monitor and identify respiratory distress for 2 of 3 R2). The facility's failures rediate jeopardy for R1 who arm when she displayed subsequently transferred to dimitted to the intensive care failures had the potential to a residents who continued to the who required physician	F 695	F695-Respiratory Care R1 is no longer in facility. R2 s CPAP s machine was check and functioning properly and has see had a mask replacement. R2 s can was updated to reflect refusals of the CPAP. Like residents include all individual BiPAP or CPAP residing at Madon Towers of Rochester. All BiPAP/C equipment was checked for proper functioning and no others have malfunctioning or broken equipment this time. As part of the abatement plan, all I nursing staff received reeducation facility is oxygen therapy policy with emphasis on provider and responsions party notification and abnormal fine following respiratory assessment. Unlicensed nursing received reeduced on hypoxia and to report confusion nursing staff received education of checking the functionality of CPAP equipment. All nursing staff were reeducated to notify the respiratory service and the DON/ED regarding malfunctioning or broken equipment.	since are plan use of Is on na PAP r nt at icensed on the th sible dings ucation n. All n //BiPAP	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245153	B. WING		1	28/2021
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP 0 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	•	0/2021
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F 695	Findings include: During an interview family member (FMR1 on 5/23/21, better FM-B stated, R1's her oxygen on via roof the cannula's ware oxygen was only seen fM-B stated she distributed barely responsive of FM-B stated he gotthereafter, R1 was ambulance where sintensive care unit, was poor. FM-B stated her BIPAP on and because she had a with severe pulmor stated R1 required BIPAP was on and 1.0-2.0 L of oxygen machine R1 used a home. FM-B stated facility of any problincluding missing portions of the restrict obstructive sleep and family members.	is not immediate jeopardy. If on 5/26/21, at 4:59 p.m., R1's 1/9. B stated he went up to visit ween 7:30 a.m. and 8:00 a.m. BIPAP was not on, she had hasal cannula, however, one as not in her nose and the let to 2.0 L (liters) instead of 3. If one look good and was when he asked her questions. If the nurse, and shortly sent to the hospital via she was in a coma in the let FM-B stated her prognosis and he remained hopeful, but in she would probably not led, R1 absolutely had to have was very faithful about using it in history of polio that left her hary hypertension. FM-B 3.0 L of oxygen when the during the day she required in FM-B stated the BIPAP at the facility was her own from the was not notified by the lems or issues with the BIPAP	F6	unlicensed nursing staff we to report any malfunctioning equipment to the nurse. A malfunctioning or broken e be called in to the respirate additional signage was posinumbers to call. To ensure ongoing complia and respiratory status will week for (3) weeks, and the weekly for an additional 3 findings will be presented to quality council by DON or residents are currently on monitoring including vitals respiratory monitoring. Licensed nursing staff rece on sign/symptoms of abnorance assessment finding(s). Uninursing staff were educated hypoxia and abnormal confeducation was provided to document form starting 05 before their next scheduled nursing staff will be educated form with competency veriof knowledge assessment 05/27/2021 or before their shift. Symptom recognition will be week for (3) weeks, and the weekly for an additional (3) EMR reporting function Report. CPAP/BiPap equip functionality will be audited.	ag or broken any equipment is to bory service and sted for ance, O2 sats be audited $5x / 100$ feel twice weeks. Audit to facility sidesignee. All covid with sats and all elived education rmal respiratory licensed and on s/s of fusion. Associates in $(27/2021)$ or dishift. All ted in document fication by way starting next scheduled are audited $5x / 100$ feel twice weeks with Facility Activity oment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING _			C 28/2021
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CO 4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901	<u> </u>	
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F 695	assessment dated have signs and sym of care behaviors. Trequired extensive member for bed mouse. R1's progress note was alert and orientime. R1's face sheet, ide facility on 5/18/21, syndrome, restrictive hypertension due to obstructive sleep appreath, presence of fibrillation, and deproxygen. R1's physician order-Patient to wear BIF oxygen twice[while 11:00 p.m., 11:00 p. 5/18/21) -Patient may use 21 activity (start date 50 p. 11 p. 12 p. 12 p. 13 p. 14 p. 15	imum Data Set (MDS) 5/23/21, indicated R1 did not optoms of delirium or rejection The MDS identified R1 physical assist from one staff obility, transfers, and toilet dated 5/18/21, indicated R1 tated to person, place, and entified R1 was admitted to the with diagnoses of post-polio re lung disease, pulmonary o lung diseases and hypoxia, onea, dyspnea, shortness of f cardiac pacemaker, atrial endence on supplemental ers included: PAP at night time with 3 L of sleeping] per day 2:30 p.mm 6:00 a.m. (start date of oxygen as needed during 6/18/21). re plan dated 5/18/21, gen related to chronic with hypoxia (did not identify rapnia), shortness of breath ated to obstructive sleep	F 69	(3) weeks, and then twice wadditional (3) weeks with the function. Audit findings will to facility as Quality Council designee. Results of monitoring shall the facility Quality Council nongoing frequency and dura determined through analysis of results.	e order audit be presented by DON or be reported at meeting with ation 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			C 05/28/2021
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE 4001 19TH AVENUE NORTHV ROCHESTER, MN 55901		00/20/2021
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F 695	saturations will be reparameters. Interversaturations as orde 2) oxygen settings a (is a treatment method sleep apnea) as orded observations in Mathand summary in produpdate care plan to to decrease symptod oxygen bleed [oxygen bleed [oxyge	maintained within prescribed entions included, 1) oxygen red. Follow up with concerns. as ordered. 3) BIPAP/CPAP mod for patients who have dered, 4) complete respiratory trix (electronic health record) orgress notes of findings. The oreflect interventions utilized oms of shortness of breath. 5) then supply tube is attached to as ordered. 6) report: mental status excessive paleness, or level of consciousness, ration. Notify physician for	F 6	95		

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

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F 695	-5/23/21, at 11:38 a mostly unresponsive nursing assistant] a arrived at the reside be in respiratory distant gasping. Reside [nasal cannula]. Vite [electronic medication it was discovered the Writer determined to system] should be by ambulance to [in care." During an interview RN-B stated he work RN-B stated he work RN-B stated he had not put that morning. RN-B R1's room, R1 had only 3 L of oxygen. Was not on because RN-B stated R1 was able to answer simple able to report her stook her vital signs RN-B indicated who morning nothing had RN-B indicated her broken piece either 5/22/21. During an interview NA-B stated she had 5/23/21. NA-B stated facility between 7:3	ge 10 I.m. "Resident was found to be this am by CNA [certified and nurse was alerted. When I ent's bedside, she appeared to stress with labored breathing lent was on 3 L 02 via NC als were taken (see eMAR on administration record]) and nat 02 sats were in the 80's. hat EMS [emergency medical called and resident was taken ame of hospital] for further on 5/27/21, at 9:09 a.m. rked the morning of 5/23/21. called him around 8:00 a.m. of R1's room right away. RN-B reviously been in R1's room a stated when he arrived to not had her BIPAP on and RN-B indicated the BIPAP et there was a piece missing. Is minimally responsive, only pole questions, and R1 was not symptoms. RN-B stated he and called the ambulance. In he started his shift that a doen reported about R1. In became aware of the BIPAP on 5/21 or evening of the GM-B had arrived at the 0 a.m. and 8:00 a.m. NA-B do her that R1 needed to be a started to be a starte	F6	95		

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AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:		` '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 695	checked. NA-B stated R1 did not have he on, and she called talkie. NA-B stated room prior. During an interview director of nursing aware R1 was miss mask and had not be should have notified a supplier for replacindicated if BIPAP/0 to missing parts/rejrespiratory status be DON also indicated been notified of R1 is a symptom of restaff had not been pertaining to CPAP last year. During an interview RN-A stated she we 5/21 and 5/22/21. Finer BIPAP mask or mask was broken soxygen via nasal cadocumentation on the stated during her sl confused, she had because of low 02 slevels were 95%. RR1's 02 saturations were stable at 95% oxygen saturations R1 must have a uri	ge 11 ed she went into R1's room, r BIPAP on, 3 L of oxygen was for RN-B using her walkie she had not been in R1's on 5/27/21, at 9:47 a.m. DON) stated she was not sing a piece to her BIPAP been used. DON stated staff d the physician and contacted been used. DON also DPAP's were not used related bections it was an expectation be monitored and documented. If the physician should have so new onset of confusion as it spiratory distress. DON stated brovided with education be an of 5/27/21, at 9:59 a.m. briked the overnight shifts on RN-A stated R1 did not wear browned the 3 L of annula. RN-A verified the she TAR was incorrect. RN-A britton 5/22/21, R1 was really thought it maybe was beaturations, although R1's N-A stated she had obtained a couple of times and they they read the stated since R1's were good, she thought that many tract infection. RN-A document the vital signs or the	F6	695			

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F 695	new onset of the conot notify the physic reported the broker could not recall if it 5/21/21 or 5/22/21. R1's record lacked notified of the new of documentation of the as the vital signs were certified nurse practices and the vital signs were certified nurse pr	ge 12 Infusion and indicated she did cian. RN-A indicated she had a BIPAP machine to RN-B but was the morning of the evidence the physician was conset of confusion and he change in cognition as well ere not documented by RN-A. In on 5/27/21, at 10:09 a.m. titioner (CNP) indicated if a re their BIPAP on, hypoxia hoxygen in the tissues to ions) could occur and ted R1 had sleep apnea so is on BIPAP at night, without ame hypoxic, this would affect and lead to decreased In of 5/27/21, at 11:50 a.m. stered nurse (SM-RN) said 1's BIPAP use was for chronic with hypercapnia. SM-RN vernight oximetry in February a good so no changes were upy. SM-RN stated there had ations since February. SM-RN ery much concerning if R1 ar the BIPAP because it was bieces, the expectation would get a loaner. SM-RN stated ng the device whenever she me hours included), in sleep longer than 30 minutes	F6	95			

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F 695	dependent upon or Review of R1's vitarion 5/20/21, R1's remonitoring between when at 6:22 a.m. If 96% on 3.0 L of oxyon 5/21/21, respiration recorded after 8-On 5/22/21, respiration recorded after 8-On 5/23/21, at 9:10 saturations were 80 108/per minute, block Respirations were 108/per	e devices however, was a respiratory condition. I signs included: ecord lacked respiratory a 9:08 p.m. and 6:22 a.m. R1's oxygen saturations were yeen. atory status/vital signs were 5:50 p.m. atory status/vital signs were 5:06 p.m. 0 a.m. R1's oxygen 6% on room air, pulse was sood pressure was 89/65.	F6	95		
	5/26/21, at 9:07 p.n	g observation times on n., 9:20 p.m., 9:35 p.m., 9:45 with his eyes closed, mouth				

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F 695	apnea. R2's had a complete table next to him and table next remained on use. Nursing assis R2 did not have his because he refused where the document the nurse had been walked into R2's recording to RN-C, RN-C asked NA-C, stated "he's refusing observed to walk to he didn't want to us wasn't going to weat been refusing his Coyelled he hasn't been refusing his complete was something somebody, and not R2's Face Sheet, in obstructive sleep and mild cognitive in extensive assistance and personal hygie.	irrations with short periods of CPAP mask on the bedside and was not in use. ion on 5/26/21, at 9:56 p.m. Iaying in bed and CPAP the bedside table and not in tant (NA)-C was asked why CPAP on, NA-C stated d. NA-C was then asked notation could be located and if a made aware. NA-C then om, asked R2 if he wanted the d "no". NA-C was observed R2 had refused his CPAP, "why, did he refuse?" NA-C g just like always." RN-C was of R2's room and asked R2 why se his CPAP. R2 told RN-C he ar it. RN-C then told R2 he had cPAP. R2 raised his voice and en refusing it, R2 indicated and wrong with it, he had told hing has been done about it. Included diagnoses of onea, congestive heart failure, mpairment. Thum Data Set (MDS) 3/2/2021, indicated R2 had pairment and required be from one staff for dressing	F 6	95		

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order for the use of R2's care plan did r R2's obstructive sle management. R2's progress note "Resident experient of breath at the time saturations at 88% note indicated a na oxygen were admir R2's oxygen saturation 2 L. R2's progress note up was done regard low oxygen saturatidiminished at both nurse practitioner was something wro not recall what it was something wro not recall what it was physician orders and CPAP was not transfered and stated documentation of RCPAP. During an interview	the CPAP. not identify a plan of care for rep apnea and/or respiratory dated 4/22/21, included cing an episode of shortness of during night shift. Oxygen on room air at the time." The rectic pain medication and histered per standing orders; tions then increased to 94% dated 4/23/21, indicted follow ding shortness of breath and ons. R2's lung sounds were lung bases and had wheezing, was notified. dated 4/26/21, included, red: OK for CPAP use". on 5/26/21, at 10:00 p.m. deremembered hearing there ing with R2's CPAP but could as. RN-C reviewed R2's record lacked into physician orders; mentation the CPAP was R2's record lacked its refusals to wear the	F6	695			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa order for the use of R2's care plan did r R2's obstructive sle management. R2's progress note "Resident experience of breath at the time saturations at 88% note indicated a na oxygen were admir R2's oxygen saturation at 2 L. R2's progress note up was done regard low oxygen saturation of 2 L. R2's progress note up was done regard low oxygen saturation of 2 L. R2's progress note up was done regard low oxygen saturation of 2 L. R2's progress note up was done regard low oxygen saturation of 2 CPAP was not trans record lacked docu applied, and stated documentation of R CPAP. During an interview licensed practical n	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 of R2's refusals to wear the	A BUILD 245153 B. WING PROVIDER OR SUPPLIER IA TOWERS OF ROCHESTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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RN-C reviewed R2's physician orders and confirmed the order for 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 10:00 p.m. licensed practical nurse (LPN)-A indicated she

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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 695	staffing agency. LP assigned to work or When asked if she and/or rejections per machine, LPN-A stadidn't know anythin did not go around a their CPAP/BIPAP runawareness of whapplication/usage. It was going do with this CPAP, LPN-A state physician. During an interview RN-D stated he was director of nursing (refused to wear his the nurse and docuresidents did not we prescribed the physician states are also docured to the physician states are also docured to wear his the nurse and docuresidents did not we prescribed the physician states are also docured to wear his the nurse and docuresidents did not we prescribed the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured to wear his the nurse and docured the physician states are also docured the nurse are also docured to wear his the nurse and docured the nurse are also docured to wear his the nurse and docured the nurse are also docu	N-A stated she had been in the unit R2 resided on. was aware of any concerns ertaining to R2's CPAP ated she didn't work here and graphout it. LPN-A stated she and check if residents had machines on, and stated an ato was monitoring the LPN-A was asked what she he knowledge R2 had refused tated she was going to notify on 5/26/21, at 10:20 p.m. is being trained as the new (DON). RN-D stated if R2 CPAP it should be reported to mented. RN-D stated if ear their CPAP/BIPAP as sician should be notified and should be monitored during the con 5/27/21, at 10:56 a.m.	F6	695			
	admitted to the faci facility called and to needed it, however months and told he FM-A stated she wa had discontinued th determined R2 did had not been notified anything wrong with	tated shortly after R2 was lity in December 2020, the old her they did not think he they called within the last few r to bring it up to the facility. The cast of aware if the physician are CPAP or how it was not need it. FM-A stated she are that there had been in the CPAP or that R2 had not M-A stated she was aware R2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245153	B. WING		l l	C 28/2021
	PROVIDER OR SUPPLIER	HESTER INC		STREET ADDRESS, CITY, STATE, ZIP CODI 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	anyway. During an interview director of nursing (something was wrostated if there was should have been robtained. An undated facility address procedures respiratory devices included: Oxygen the in a safe manner as provider. Residents respiratory needs a identified in need or interventions/equip accordance with the 6) document assess status, tolerance, vistatus in medical remanufacturer record handling, cleaning, dispensing, mainted accordance with maconsistent with federegulations. The immediate jeon was removed on 5/completed the followall in the followall	on 5/27/21, at 9:47 a.m. (DON) was not aware that any with R2's CPAP. DON something wrong, the supplier notified and necessary part policy Oxygen Therapy did not a for malfunctioning or broken dequipment. The policy nerapy is provided to residents are assessed to ensure their are being met. Residents foxygen therapy have ment implemented in a resident-centered care plantal signs, and respiratory as necessary. 7) Follow numendations for safe humidification, storage, and nance of equipment in anufacturer specifications and paraly that began on 5/20/21 28/21, when the facility	F6	95		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245153	B. WING				C 28/2021
	PROVIDER OR SUPPLIER			4001 19TI	DDRESS, CITY, STATE, ZIP CODE H AVENUE NORTHWEST STER, MN 55901	1 00//	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	B) Licensed nursing sign/symptoms of a assessment finding C) All nursing staff functionality of CPA notification procedubroken equipment. D) An auditing systematic procedure of the companion of	g staff were educated on abnormal respiratory is. were educated on checking AP/BIPAP equipment and ires of malfunctioning or em was developed and entifying signs/symptoms of	F	95			



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 <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

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

(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		
		00419	B. WING		C 05/29	3/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS CITY S	STATE, ZIP CODE	1 03/20	72021
	NA TOWERS OF ROC	4001 19T	H AVENUE N			
WADONI	NA TOWERS OF ROC	ROCHES	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- 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 that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found to the MN State Licen electronic plan of co	TS: 21, a complaint survey was acility by surveyors from the nent of Health (MDH). Your be NOT in compliance with sure. Please indicate in your prrection you have reviewed dentify the date when they will				

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

Electronically Signed 06/23/21

TITLE

STATE FORM 6899 If continuation sheet 1 of 15 V70U11

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00419	B. WING		05/2) 8/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	05/2	.0/2021
MADON	NA TOWERS OF ROC	HESTER INC		ORTHWEST		
	OUR MARRY OTA		TER, MN 55		011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	be completed.					
	SUBSTANTIATED: and MN00073191) at 0830. Minnesota Departmenthe State Licensing Federal software. The state state of the state of the correction order the findings which a statute after the state of the correction order the findings which a statute after the state of the state	p participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health

STATE FORM 6899 V70U11 If continuation sheet 2 of 15

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00419		B. WING		05/2	28/2021
		00413				03/2	.0/2021
NAME OF I	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 DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ae 2		2 000			
	facility is enrolled in signature is not req page of state form.	ePOC and therefore uired at the bottom o	f the first				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING I WHICH STATES, N OF CORRECTION RAL DEFICIENCIES R ON EACH PAGE.	N." THIS				
2 830	MN Rule 4658.0520 Proper Nursing Car		and	2 830			7/6/21
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. At be out of bed as muis a written order from	general. A resident e and treatment, persupervision based of d preferences as ide resident assessment assessment assessment as possible unlessement as possible unlessement attending physist remain in bed.	sonal and n ntified in t and .0400 nt must ss there sician				
	by: Based on observati review, the facility fordered respiratory appropriately, notify in cognition and fai signs/symptoms of residents (R1 and F resulted in an imme	ent is not met as evi- on, interview, and do ailed to ensure physi devices were function the physician with a led to monitor and id respiratory distress f R2). The facility's fails ediate jeopardy for R rm when she display	ocument cian oning change entify or 2 of 3 ures 1 who		Corrected.		

Minnesota Department of Health

STATE FORM 6899 V70U11 If continuation sheet 3 of 15

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00419	B. WING			8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	HAVENUE N FER, MN 559	ORTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 830	Continued From page 3		2 830			
	the hospital, and ac unit. The facility's f effect addition 3 of	, subsequently transferred to dmitted to the intensive care failures had the potential to 3 residents who continued to who required physician devices.				
	the facility failed to components of BIP that pushes air in a with breathing) made respiratory manage 5/27/21. The direct administrator, and training were notificat 2:25 p.m. on 5/2 was removed on 5/remained at the low isolated scope and no actual harm with	pardy began on 5/20/21, when report and replace necessary AP (non-invasive ventilator and out of the lungs to help chine to ensure adequate ement and was identified on or of nursing (DON), the director of nursing in ed of the immediate jeopardy 7/21. The immediate jeopardy 28/21, but non-compliance wer scope and severity of D-severity level, which indicated a potential for more than is not immediate jeopardy.				
	family member (FM R1 on 5/23/21, between FM-B stated, R1's I her oxygen on via rof the cannula's war oxygen was only see FM-B stated she dibarely responsive were stated he got thereafter, R1 was ambulance where sintensive care unit.	on 5/26/21, at 4:59 p.m., R1's I)-B stated he went up to visit ween 7:30 a.m. and 8:00 a.m. BIPAP was not on, she had hasal cannula, however, one is not in her nose and the let to 2.0 L (liters) instead of 3. In the look good and was when he asked her questions. It the nurse, and shortly sent to the hospital via she was in a coma in the FM-B stated her prognosis aid he remained hopeful, but				

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Minnesota Department of Health STATE FORM

V70U11 If continuation sheet 4 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
						С
		00419	B. WING		05/2	28/2021
	PROVIDER OR SUPPLIER	4001 1	ADDRESS, CITY, S	STATE, ZIP CODE IORTHWEST		
MADONI	NA TOWERS OF ROC	ROCHI	STER, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	the doctors told him	n she would probably not	2 830			
	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 pulmon stated R1 required	nary hypertension. FM-B 3.0 L of oxygen when the during the day she required				
	1.0-2.0 L of oxygen machine R1 used a home. FM-B stated	i. FM-B stated the BIPAP at the facility was her own fro the was not notified by the				
	including missing p	ems or issues with the BIPAI arts.				
	included diagnosis hypercapnia and in related to the restric obstructive sleep a	arge summary dated 5/18/21 of chronic respiratory with dicated the hypercapnia was ctive lung disease and pnea. The discharge summa ed BIPAP to manage sleep				
	assessment dated shave signs and synof care behaviors. Trequired extensive	nimum Data Set (MDS) 5/23/21, indicated R1 did no nptoms of delirium or rejection The MDS identified R1 physical assist from one state obility, transfers, and toilet	n			
		dated 5/18/21, indicated R1 tated to person, place, and				
	facility on 5/18/21, v syndrome, restrictiv hypertension due to obstructive sleep a	entified R1 was admitted to t with diagnoses of post-polio re lung disease, pulmonary o lung diseases and hypoxia pnea, dyspnea, shortness of f cardiac pacemaker, atrial				

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Minnesota Department of Health

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		05/2	8/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADON	NA TOWERS OF ROC	HESTER INC	H AVENUE N TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	fibrillation, and dep oxygen. R1's physician order-Patient to wear BIF oxygen twice[while 11:00 p.m., 11:00 p.5/18/21) -Patient may use 2 activity (start date 5 respiratory calincluded: Uses oxyrespiratory failure with diagnosis of hyperorand uses BIPAP reapnea. R1's goal indicated signs/symptoms of saturations will be reparameters. Intervesaturations as order 2) oxygen settings (is a treatment met sleep apnea) as order 2) oxygen settings (is a treatment met sleep apnea) as order 2) oxygen bleed [oxygen bleed [oxy	endence on supplemental ers included: PAP at night time with 3 L of sleeping] per day 2:30 p.mm 6:00 a.m. (start date L of oxygen as needed during 5/18/21). re plan dated 5/18/21, gen related to chronic with hypoxia (did not identify capnia), shortness of breath lated to obstructive sleep R1 would not have respiratory distress and maintained within prescribed entions included, 1) oxygen ared. Follow up with concerns. as ordered. 3) BIPAP/CPAP hod for patients who have dered, 4) complete respiratory trix (electronic health record) orges notes of findings. The profit of shortness of breath. 5) gen supply tube is attached to be as ordered. 6) report: mental status excessive paleness, and revel of consciousness, ration. Notify physician for	2 830			

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Minnesota Department of Health

AND DI AN OF CORRECTION (INCIDENTIFICATION NI IMPER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00419		B. WING		05/2	8/2021	
NAME OF	PROVIDER OR SUPPLIER	L	DRESS, CITY, S	STATE, ZIP CODE	1 00:2	0,2021
MADON	NA TOWERS OF ROC	HESTER INC	HAVENUE N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	-5/21/21, at 6:25 a. piece of her CPAP to head piece, unal administered via na overnight order." R1's record lacked notified R1 had not evidence the facility part. -5/21/21, at 9:50 p. the BIPAP on becabroken." Although I record (TAR) identic checked the box in -5/23/21, at 11:38 a mostly unresponsiv nursing assistant] a arrived at the residue in respiratory disand gasping. Resident and gasping. Resident it was discovered the Writer determined to system] should be by ambulance to [In care." During an interview RN-B stated NA-B requesting he go to	m. "Resident is missing a [sic], clip for mask to connect ole to locate. 02 (oxygen) asal cannula at 3 L/min per evidence the physician was used her BIPAP and or y had obtained a replacement m. indicated R1 did not have use "strip on right side R1's treatment administration fied registered nurse (RN)-A dicating the BIPAP was on R1. a.m. "Resident was found to be to this am by CNA [certified and nurse was alerted. When I lent's bedside, she appeared to stress with labored breathing lent was on 3 L 02 via NC als were taken (see eMAR ion administration record]) and that 02 sats were in the 80's. that EMS [emergency medical called and resident was taken ame of hospital] for further on 5/27/21, at 9:09 a.m. rked the morning of 5/23/21. called him around 8:00 a.m. of R1's room right away. RN-B				
	and gasping. Resic [nasal cannula]. Vit [electronic medicat it was discovered the Writer determined to system] should be by ambulance to [n care." During an interview RN-B stated he wo RN-B stated NA-B requesting he go to stated he had not puthat morning. RN-B	lent was on 3 L 02 via NC als were taken (see eMAR ion administration record]) and nat 02 sats were in the 80's. that EMS [emergency medical called and resident was taken ame of hospital] for further on 5/27/21, at 9:09 a.m. rked the morning of 5/23/21. called him around 8:00 a.m.				

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Minnesota Department of Health STATE FORM

V70U11 If continuation sheet 7 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND I DAY OF CONTROL OF THE PROPERTY OF THE PR		A. BUILDING:		COMPLETED		
		00419	B. WING		05/2	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	only 3 L of oxygen. was not on becaus RN-B stated R1 was able to answer sim able to report her stook her vital signs RN-B indicated who morning nothing has RN-B indicated he broken piece either 5/22/21. During an interview NA-B stated she has 5/23/21. NA-B stated FM-B notifie checked. NA-B stated FM-B notifie checked. NA-B stated FM-B stated room prior. During an interview director of nursing aware R1 was miss mask and had not I should have notifie a supplier for replacindicated if BIPAP/to missing parts/rej respiratory status b DON also indicated been notified of R1 is a symptom of restaff had not been simple staff had not been sim	RN-B indicated the BIPAP et here was a piece missing. Is minimally responsive, only ple questions, and R1 was not ymptoms. RN-B stated he and called the ambulance. In he started his shift that indicate became aware of the BIPAP on 5/21 or evening of ed FM-B had arrived at the following of ed FM-B had arrived at the following on a.m. NA-B of her that R1 needed to be sted she went into R1's room, or BIPAP on, 3 L of oxygen was for RN-B using her walkie she had not been in R1's end on 5/27/21, at 9:47 a.m. (DON) stated she was not sing a piece to her BIPAP opeen used. DON stated staff of the physician and contacted dement parts. DON also CPAP's were not used related ections it was an expectation be monitored and documented. If the physician should have its new onset of confusion as it spiratory distress. DON stated provided with education /BIPAP machines within the	2 830			

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Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
VIAD I. FVIA	O. COMMEDITION	IDENTIFICATION NOWIDEN.	A. BUILDING:		COWIFLETED	
		00419	B. WING			8/2021
					1 00:2	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC 4001 19T	H AVENUE N	ORTHWEST		
MADOM	NA TOWERS OF ROC	ROCHES	TER, MN 55	901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
2 830	Continued From pa	ige 8	2 830			
	-					
		on 5/27/21, at 9:59 a.m.				
		orked the overnight shifts on				
		RN-A stated R1 did not wear				
		n 5/21 or 5/22/21, because the				
		so she applied the 3 L of				
	, , ,	annula. RN-A verified the				
		the TAR was incorrect. RN-A				
		hift on 5/22/21, R1 was really				
		thought it maybe was				
		saturations, although R1's				
		N-A stated she had obtained				
		a couple of times and they				
		; RN-A stated since R1's				
		were good, she thought that				
		nary tract infection. RN-A				
		document the vital signs or the				
		onfusion and indicated she did				
		cian. RN-A indicated she had				
		n BIPAP machine to RN-B but				
		was the morning of the				
	5/21/21 or 5/22/21.					
		evidence the physician was				
		onset of confusion and				
		ne change in cognition as well				
	as the vital signs w	ere not documented by RN-A.				
		on 5/27/21, at 10:09 a.m.				
		titioner (CNP) indicated if a				
		ve their BIPAP on, hypoxia				
		h oxygen in the tissues to				
	sustain bodily funct	tions) could occur and				
	confusion. CNP sta	ited Ŕ1 had sleep apnea so				
		s on BIPAP at night, without				
		ame hypoxic, this would affect				
		ind lead to decreased				
	respiratory drive.					
	, ,					
	During an interview	on 5/27/21, at 11:50 a.m.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
		00419	B. WING		05/2	, 8/2021
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 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)	LD BE	(X5) COMPLETE DATE
2 830	sleep medicine regithe indication for R respiratory failure wistated R1 had an or 2021, oximetry was needed to the therabeen no communiciated it would be was not wearing the was not able to wear broken or missing pube to get it fixed or R1 should be wearing was sleeping (dayting general if patients as they should use the dependent upon on Review of R1's vitation 5/20/21, R1's remonitoring between when at 6:22 a.m. Fig. 96% on 3.0 L of oxyon 5/21/21, respiration recorded after 5-On 5/22/21, respiration recorded after 5-On 5/23/21, at 9:10 saturations were 86108/per minute, blo Respirations were responsible to a indicated staff had a st	istered nurse (SM-RN) said 1's BIPAP use was for chronic vith hypercapnia. SM-RN vernight oximetry in February good so no changes were upy. SM-RN stated there had ations since February. SM-RN very much concerning if R1 e BIPAP for 2 nights, and if R1 ar the BIPAP because it was bieces, the expectation would get a loaner. SM-RN stated ing the device whenever she me hours included), in sleep longer than 30 minutes e devices however, was a respiratory condition. I signs included: ecord lacked respiratory in 9:08 p.m. and 6:22 a.m. R1's oxygen saturations were vgen. atory status/vital signs were 5:50 p.m. atory status/vital signs were 5:06 p.m. 0 a.m. R1's oxygen 6% on room air, pulse was od pressure was 89/65.	2 830			

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AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
	00419	B. WING		05/2	8/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
MADONNA TOWERS OF ROCH	ESTER INC	I AVENUE N TER, MN 559	ORTHWEST 901			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE	
0.000		0.000	DEFICIENCY)			
p.m. FM-B stated R1 care unit (ICU), prog stated the facility had missing part of BIPAl could have been avoobtained a part from where to go to get or R2 During the following 5/26/21, at 9:07 p.m. p.m. R2 laid in bed wopen, shallow respira apnea. R2's had a C table next to him and During an observation R2's contined to be I mask remained on the use. Nursing assista R2 did not have his C because he refused. where the document the nurse had been refused into R2's roof CPAP on, R2 stated reporting to RN-C, FRN-C asked NA-C, stated "he's refusing observed to walk to he didn't want to use wasn't going to wear been refusing his CF yelled he hasn't beer there was something	terview on 5/27/21, at 4:45 I remained in the intensive nosis was unchanged. FM-B d not notified him of the P mask, and indicated that bided, he could have their supplier or told them ne, "this is very unfortunate". observation times on ., 9:20 p.m., 9:35 p.m., 9:45 with his eyes closed, mouth ations with short periods of PAP mask on the bedside	2 830				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00419		B. WING			C 28/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	0/2021
		4001 19T	H AVENUE N			
MADONI	NA TOWERS OF ROC	HESTER INC ROCHES	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	R2's Face Sheet, ir	oncluded diagnoses of ponea, congestive heart failure,				
	assessment dated severe cognitive im	mum Data Set (MDS) 3/2/2021, indicated R2 had pairment and required be from one staff for dressing ne.				
	CPAP mask and res	ders included instruction on servoir cleaning/disinfecting , however did not identify an the CPAP.				
		not identify a plan of care for eep apnea and/or respiratory				
	"Resident experient of breath at the time saturations at 88% note indicated a na oxygen were admir	dated 4/22/21, included cing an episode of shortness e of during night shift. Oxygen on room air at the time." The rcotic pain medication and histered per standing orders; tions then increased to 94%				
	up was done regard low oxygen saturati	dated 4/23/21, indicted follow ding shortness of breath and fons. R2's lung sounds were lung bases and had wheezing, was notified.	,			
		dated 4/26/21, included, ed: OK for CPAP use".				
		on 5/26/21, at 10:00 p.m. d remembered hearing there				

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING:	A. BUILDING:		С	
		00419	B. WING			8/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE		
MADONI	NA TOWERS OF ROC	HESTER INC	TH AVENUE N			
(VA) ID	STIMMADV STA	ATEMENT OF DEFICIENCIES	STER, MN 55	PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 12	2 830			
	not recall what it was physician orders ar CPAP was not transrecord lacked docu applied, and stated documentation of FCPAP. During an interview licensed practical necessity.					
	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.					
	RN-D stated he wa director of nursing of refused to wear his the nurse and docu- residents did not we prescribed the physical respiratory status sonight.	on 5/26/21, at 10:20 p.m. as being trained as the new (DON). RN-D stated if R2 cPAP it should be reported to umented. RN-D stated if ear their CPAP/BIPAP as sician should be notified and should be monitored during the on 5/27/21, at 10:56 a.m.				
	family member (FM	I)-A stated R2's CPAP was ne last 2 years and he used it				

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER					SURVEY PLETED	
		00419	B. WING			C 28/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS CITY S	STATE, ZIP CODE	1 00/2	10/2021
		4001 197	H AVENUE N			
MADONI	NA TOWERS OF ROC	HESTER INC ROCHES	STER, MN 559	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	at bedtime. FM-A standmitted to the faci facility called and to needed it, however months and told he FM-A stated she was had discontinued the determined R2 did had not been notificanything wrong with been wearing it. FM did not like wearing anyway. During an interview director of nursing (something was wro stated if there was should have been robtained. An undated facility address procedures respiratory devices included: Oxygen the in a safe manner as provider. Residents respiratory needs a identified in need of interventions/equipmaccordance with the 6) document assess status, tolerance, vistatus in medical remanufacturer recommunications.	tated shortly after R2 was lity in December 2020, the old her they did not think he they called within the last few r to bring it up to the facility. As not aware if the physician are CPAP or how it was not need it. FM-A stated she are determined that there had been in the CPAP or that R2 had not also also also also also also also also	t	DEFICIENCY)		
	accordance with ma	nance of equipment in anufacturer specifications and eral, state, and local laws and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:			С	
		00419	B. WING			8/2021
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 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 14	2 830			
	regulations.					
	The immediate jeop was removed on 5/completed the follor A) Licensed nursing facility's oxygen the provider and responsion abnormal findings fassessments. B) Licensed nursing sign/symptoms of assessment finding C) All nursing staff functionality of CPA notification procedubroken equipment. D) An auditing syst implemented for iderespiratory distress functionality. SUGGESTED MET director of nursing/creview/revise/devel respiratory devices The DON/designee provide education a devices. The DON/and implement an afacility's quality assongoing compliance.	g staff were reeducated on erapy policy with emphasis on nsible party notification of following respiratory g staff were educated on abnormal respiratory gs. were educated on checking AP/BIPAP equipment and ures of malfunctioning or em was developed and entifying signs/symptoms of and CPAP/BIPAP THOD OF CORRECTION: The designee could lop policies and procedures used for airway management. It could then develop and and training of respiratory designee could the develop auditing system as part of the lurance program to assure				

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