DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2022

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

RE: CCN: 245153
Cycle Start Date: July 5, 2022

Dear Administrator:

On July 15, 2022, we notified you a remedy was imposed. On September 2, 2022 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 August 25, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 30, 2022 be discontinued as of August 25, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 15, 2022, 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 July 5, 2022. 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2022

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

Re: Reinspection Results
Event ID: U4DE12

Dear Administrator:

On September 2, 2022 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 August 3, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2022

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

RE: CCN: 245153
Cycle Start Date: July 5, 2022

Dear Administrator:

On July 15, 2022, we informed you of imposed enforcement remedies.

On August 3, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be 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 July 30, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 30, 2022, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 30, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 30, 2022.

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.

As we notified you in our letter of July 15, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide

Training and/or Competency Evaluation Programs (NATCEP) for two years from July 5, 2022.

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 July 5, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions

(42 CFR 488.417 (a));

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 January 5, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

determination.

APPEAL RIGHTS

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/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 08/03/2022

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 7/27/22 thru 8/3/22, 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: H51533277C (MN85014), with a deficiency cited at F689. AND The following complaint was found to be UNSUBSTANTIATED, however a related deficiencies was cited.. H51533501C (MN83646), with a deficiency cited at F689.. The survey resulted in an Immediate Jeopardy (IJ) at F689 when when it was discovered the facility failed to have a system in place to protect residents related to falls, including a lack of analysis of fall incidents to determine root cause. Additionally, the facility did not reassess residents following falls to determine and implement appropriate interventions to protect the residents. The facility administrator and director of nursing (DON) were notified of the IJ on 7/29/22 at 10:33 a.m. The IJ began on 7/11/22, and the immediacy was removed effective 7/30/22. The above findings constituted substandard quality of care; an extended survey had been recently conducted on 7/1/22 and no changes have occurred since that date.	F 000		

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

Electronically Signed | 08/25/2022

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 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess falls and identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 2 of 3 residents (R1, R2) reviewed for accidents. R1 who had 11 falls, nine falls from a Broda chair with six falls unwitnessed. On 7/10/22 R1 was left alone in her room after placed in her Broda chair, fell and sustained a fracture. On 5/18/22, R2 fell during the night after she got up unattended to go to the bathroom resulting in a fracture. R2 has fallen an additional	F 689	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident#1 was evaluated post fall on 7/10/22 in the ER and returned with no	8/25/22

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F 689	Continued From page 2 14 times; each of the 14 falls occurred in R2 ' s room when alone and unsupervised. These deficient practices resulted in immediate jeopardy. An immediate jeopardy began on 7/11/22 when it was discovered, R1 fell from the Broda chair and sustained a left acetabulum and pubic fracture and was admitted to the hospital. The facility administrator and director of nursing (DON) were notified of the IJ on 7/29/22 at 10:33 a.m. The IJ was removed effective 7/30/22 when the facility revised residents care plan, completed therapy evaluation and provided staff training, but noncompliance remained at the lower scope and severity level 2- 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: R1's significant change Minimum Data Set (MDS) assessment dated 7/14/22, indicated R1 had more than two falls and one resulted in a major injury, R1 is severely cognitively impaired and needs extensive assist of 2 persons for bed mobility and transfers and did not walk during the assessment period. The MDS indicated use of a wheelchair for mobility and transfers. R1's MDS further indicated R1 was incontinent of bowel and bladder and currently on hospice. R1's care plan interventions dated 4/11/21, include: keep call light in reach, provide assist of 2 with lift for toileting. R1's care plan dated 3/10/21 indicates R1 cannot verbally ask for assistance and requires 2 assist to use the bathroom. In addition, R1's care plan included,	F 689	new orders or changes to plan of care. Fracture did not require surgical intervention. Care plan was reviewed and updated by IDT upon review of fall. Order for therapy evaluation for broda chair seating and positioning ordered 7/29/22. Therapist completed evaluation on 7/29/22; recommendation for trial wedge cushion to assist in proper seating while allowing resident to continue self-propel ability when up in chair and decrease risk of un-purposeful transfer attempts to promote increased safety and lower risk of mechanical ground fall. Resident Responsible Party informed of evaluation and recommendation and verbalized consent and agreement with changes to plan of care. Care plan updated by DON on 7/29/22 with education provided to staff on unit. Resident #2 was evaluated post fall on 5/16/22 and returned to facility without surgical intervention per family wishes for no aggressive treatment. Care plan was reviewed and updated by IDT upon review of fall. Staff was re-educated by DON/Administrator on 7/29/22 and care plan revised to include resident is not to be left unattended on the toilet. Resident #3 is no longer a resident of facility. Care plans for Resident #1 and Resident #2 were reviewed by IDT 7/29/22 including risk factors, history of falls, and current plan of care; and updated to include appropriate and current interventions to decrease risk of falls and/or significant injury to resident and	

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F 689	Continued From page 3 R1 to remain in common area until ready for bed. R1 also has a history of falls related to muscle weakness, dementia with Lewy bodies and behaviors. R1's care plan goal was not to sustain a fall with injury through the review date. Furthermore, R1's care plan also included frequently check in room at least 1-2 hours or as needed, instruct staff to follow the same routine each day and to analyze resident's falls and follow fall policy. During an observation on 7/28/22, at 9:40 a.m. R1 was seated in the Broda chair by the nurses station, no table and no activities provided. R1 staring blankly at the wall or window. R1's record review indicated previous falls: R1 had 2 falls on 1/11/22. First fall- R1 was found after she had fallen from her recliner and the second fall that day R1 fell from her Broda in the common area. R1's fall documentation for incidents occurring on 3/25/22, 3/28/22 and 3/31/22, indicated R1 fell from the Broda chair because she was unfamiliar with the Broda chair. R1 since received her personal Broda chair and no further falls from the Broda chair had occurred. The facility documentation lacked an identification of causative factor, an analysis of why R1 continued to get up from the Broda and had not placed effective interventions to prevent future falls. R1's fall event report dated 5/16/22 includes, Housekeeping staff notified writer resident was sitting on the floor at 3:20 p.m. Writer noted resident to be sitting on the floor at the nurse station by a table, she was sitting with her legs tucked under her, trying to stand herself up.	F 689	promote increased safety of residents identified. The review included risk factors, diagnosis, and history of prior falls including circumstances and contributing factors. Residents determined to be at risk for falls, determined by review related to diagnosis, prior history, and assessment review have the potential to be affected. Nine residents including R1 and R2 were identified by review on 7/29/22 at high risk for falls related to risk factors, history of multiple falls, and cognitive abilities. Care plans were reviewed and updated by Clinical management staff on 7/29/22 for specific, individualized interventions related to their identified risks. IDT will continue to review and identify risk factors, root cause of fall and update Care plan according to findings to ensure appropriate interventions are implemented and monitored for tolerance and effect for other residents found to be at risk for falls. This will be completed by 8/2/22. Interventions will be monitored by observations during rounds, review of progress notes, random staff interviews, and during AM clinical meeting. Revisions to care plan interventions will be made as needed at time of determination of need to change or revise. The facility's policy on Falls Management has been reviewed and no changes are indicated at this time. Fall prevention is addressed during admission/readmission process, baseline care plan development,	

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F 689	Continued From page 4 Resident was wearing shoes at the time, but noted a pair of shoes to be under the table that it seemed resident was reaching for and either stood herself up or bent forward and slid out. Immediate intervention: staff will remove any items (shoes, etc) from the floor around resident to prevent her from reaching for them. She was toileted about 35 minutes prior to this. R1 was screened by therapy three days later (5/19/22) with no services indicated. R1's fall event report dated 5/19/22 includes, Resident attempted to stand up on her own and ended up falling on the floor on her bottom. Fall was witnessed. Resident was in common area by nursing station after lunch. Had been given activities and seen 30 seconds prior by multiple staff. R1 was screened by therapy 14 days later (6/2/22) with no services indicated. R1's fall event report dated 6/5/22 includes, Resident had an unwitnessed fall in room late this afternoon. Resident had just been toileted and had her clothes changed by aides. Resident was left in room watching TV in her Broda chair. Aides stated she left room to assist with something and came back and resident was on the floor. Resident had one sock on and one sock off. Resident took out a drawer from a cabinet and sat in it. Resident was lifted with Hoyer back into her Broda chair with the assistance of two aides and brought out to common area. Events 5/16/22, 5/19/22 and 6/5/22, were reviewed and closed on 7/7/22 by facility interdisciplinary team (IDT). The review note includes, "On 5/16 resident had an unwitnessed fall by the nurses station. She was attempting to pick up shoes off the floor. No injuries noted. On	F 689	care plan development, and upon completion of risk assessments per facility protocol as well as further review if a fall occurs. Current facility staff, including agency/contract will be re-educated by DON/Clinical management staff beginning on 7/29/22 in relation to Fall Management policy and procedures Audits will be performed by Clinical Management team related to falls management, investigation process, and monitoring/reviewing of individualized resident interventions 3x weekly x8 weeks, then 2x weekly x4 weeks, then as needed to validate ongoing compliance. Audits will be brought through facility QAPI committee monthly for further review and recommendations if needed. Audits will not be discontinued until sustained ongoing compliance is determined by facility QAPI committee. DON/Designee is Responsible Date Certain: 8/25/22	

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F 689	Continued From page 5 5/19, resident had a witnessed fall by the nurses station. No injuries noted. On 6/5, resident had an unwitnessed fall in her room while sitting in her Broda chair. Resident is at risk for falls d/t [due to] prescribed antidepressant medication with dx [diagnosis] of depression, melatonin with a dx of insomnia, HTN [hypertension] with prescribed antihypertensive medication and most recent BIMS [brief interview for mental status] of 0 indicating severe cognitive impairment. RCA[root cause analysis]: poor safety awareness. Interventions include: Ensure floor is free from clutter in residents surroundings, Offer the toilet resident upon arising, before and/or after meals at HS[bedtime] and prn[as needed] and do [sic] leave resident unattended in Broda chair in her room. R1's care plan lacked the interventions discussed in the IDT meeting. During an interview on 7/27/22, at 1:56 p.m. trained medication assistant (TMA)-A stated he felt everyone knew R1 should be brought to the common area and should not be left alone in R1's room. TMA-A stated he looks in the care guide for fall interventions for all residents in the facility. During an interview on 7/27/22, at 2:06 p.m. TMA-B stated she worked on 7/11/22, the day after R1's fall with major injury. TMA-B stated staff usually toilet R1 after getting her up and then R1 is brought to common room. TMA-B stated R1 should not have been alone in her room on 7/10/22. During an interview on 7/27/22, at 2:20 p.m. nursing assistant (NA)-B stated he observed R1 on the floor in her room on 7/10/22 and called to	F 689		

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F 689	Continued From page 6 the nurse. NA-B stated he had seen her previously in her Broda chair after breakfast . NA-B stated, "Everybody knows not to leave her in her room because she will get up. I was surprised to see her alone in her room." During an interview on 7/27/22, at 2:26 p.m. registered nurse (RN)-B who is familiar with R1 and takes care of her one or two times a week. RN-B was aware of R1's fall with injury. RN-B added the reason for the fall was because R1 was left alone in her room. RN-B stated she believed a night shift staff had gotten her up and left R1 in her room alone. RN-B stated she would not leave R1 alone in her room if she is awake unless requested to do so by hospice or a visitor. During an interview on 7/27/22, at 2:38 p.m. director of nursing (DON) stated the expectation is all staff are to know the interventions and ways of caring for the residents. Resident interventions for falls are in the care plan. During an interview on 7/27/22, at 3:20 p.m. licensed practical nurse (LPN)-A stated she was R1's nurse at the time of the fall on 7/10/22. LPN-A stated she was not aware of R1 being alone in her room in the chair prior to the fall. LPN-A stated if R1 is in her chair she keeps her up near the nurses station. LPN-A stated she was not aware of the intervention indicating R1 is not to be left alone in her room. LPN-A said she was aware there was a sign above R1's bed that read she should not be left in her room alone. LPN-A was not aware when the sign was hung in R1's room. LPN-A said she was not aware of any interventions added to the care plan after R1's fall on 7/10/22.	F 689		

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F 689	Continued From page 7 During an interview on 7/28/22, at 1:55 p.m. certified nurse practitioner (CNP)-A stated facility staff contacts her after a fall. CNP-A stated R1 is a challenge and feels the facility is attempting to prevent further falls. CNP-A even has prevented R1 from falling when walking by the nurses station. CNP-A stated she did feel the Broda chair is appropriate and the best seating option for R1. During an interview on 7/28/22, at 2:41 p.m. occupational therapy (OT) verified R1 was last on caseload April 15 th to May 6th, 2022 related to impairments in transfers. OT had last seen her January 13th of 2021. OT indicated R1 had not evaluated a wheelchair or Broda chair. During an interview on 7/28/22, at 4:08 p.m. DON stated the facility does not have a current audit process in place to monitor the effectiveness of interventions placed in the care plan. DON indicated the facility uses general observations exampled by; if a resident moves to a new room and it is observed the resident had non skid strips on the floor and or grab bars on the bed, they are moved or installed in the new room. Interventions in the computer are monitored by audits such as the tasks the nurses complete. DON stated if the interventions are not on the care plan he said, "it doesn't matter how good it is". Once the IDT are completed with the review and interventions they should be placed in the care plan right away. DON verified if the interventions are not in the care plan staff are not aware of any new interventions developed. The DON's expectation after the IDT meeting would have been for the nurse manager to place the discussed interventions in the care plan related to R1's falls.	F 689		

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F 689	Continued From page 8 During an interview on 7/29/22, at 8:24 p.m. regional director clinical services (RDCS) stated she had met with quality assurance performance improvement (QAPI) and talked about fall management program and was currently working with a consultant from Pathways. She stated they are working on falls and working on investigations. RDCS indicated quality assurance improvement program meeting had lots of falls discussed and improving the IDT process including investigations. RDCS added her expectations would be to have falls brought to quality assurance and audits should continue to be addressed until compliance is met. Adding, falls are one of the biggest risks. When asked about the closing of the event reports after an incident she said, "The closing of the falls event needs to look at closer as a process, there are currently no standard in this building. The goal is with in one week I would say is reasonably." R2's significant change MDS assessment dated 6/28/22 indicated R2 had cognitive impairment, Parkinson's disease with dementia, and suffered from anxiety. The MDS indicated R2 required the regular use of an anti-psychotic and anti-depressant medication. The MDS also indicated R2 required the extensive assistance of 1-2 persons with bed mobility, transfers and ambulation, as well as with dressing, grooming and toileting. MDS also indicated R2 suffered from falls and was recovering from a fracture related to a fall. R2's progress notes indicated R2 had been	F 689		

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F 689	Continued From page 9 admitted to the facility in April of 2022 for rehabilitation services with the goal of returning to assisted living after a fall that required hospitalization. R2's care plan included a problem list initiated 5/5/22 and updated 7/11/22 indicating, "Resident is at high risk for falling due to multiple pelvic fx, h/o [history of] falling, Parkinson's disease, weakness, poor vision, frequency of micturition [urination], altered mental status, impaired mobility. Fall risk evaluation score indicates high risk for falls." Interventions included, "fall prevention/reduction precautions per facility protocol," and "toileting per urinary/bowel section of this care plan." The intervention in that section of the care plan indicated, "offer toileting in AM upon arising, before and after meals, at HS [bedtime] and with nightly rounds." R2's medical record indicated R2 suffered 14 incidents where she fell or ended up on the floor. On 5/18/22, R2 was found on the floor in her bathroom at around 2:30 a.m. According to a progress note, R2 stated she wanted to go to the emergency department (ED). Subsequently, the facility received a call from the hospital to let them know R2 would be returning to the facility later in the day, and R2 had suffered a left femur fracture subsequent to the fall, but would not require surgical intervention. R2 had reported hitting her head when she fell and suffered a hematoma (collection of blood outside of the blood vessels) injury. R2's medical record events (incident reports) and progress notes lacked evidence showing analysis was done to identify the root cause of R2's falls.	F 689		

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F 689	Continued From page 10 R2's care plan fall interventions lacked fall prevention interventions. In addition, despite the 5/18/22 fall having occurred in the bathroom, the facility failed to add new intervention timely. The next update to R2's fall care plan was placed on 5/23/22 and indicated the room had been rearranged to R2's preference. In relations to subsequent falls, interventions were added including, "5/27/22, bed in low position with fall mat at bedside," "5/31/22, have resident in commons area when awake as she will allow," "6/27/22, bring resident to the nurses' station after meals until staff can toilet resident-do not bring her to her room after meals unless she can be toileted right away," "6/27/22, assist resident with toileting every 2-3 hours and as needed per her request" and on "7/7/22, staff will complete 30 minute safety checks on resident any time she is in her room without family present. Continue to encourage her to sit at station between meals as she is willing." During an observation and interview 7/27/22, at 12:55 p.m. R2 was observed in her room seated in a reclining Broda chair. R2 had a family member (FM)-A visiting. FM-A stated he was aware R2 fell frequently. FM-A stated he felt R2 was likely to continue to fall due to her Parkinson's and the length of facility halls and the time it would take any person to walk to R2's room. During an interview on 7/27/22, at 2:39 p.m. R2 was not oriented to the time of day. R2 stated she was aware she was prone to fall, but was unable to state anything about the falls, when or why she had fallen. During an interview on 7/27/22, at 2:44 p.m. a	F 689		

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F 689	Continued From page 11 NA-B stated staff knew how to take care of any resident by looking at their care plan. NA-B stated fall prevention interventions in general included making sure residents are always left in a safe place, and were positioned appropriately. During an interview on 7/27/22, at 2:46 p.m. NA-C stated staff would know how to care for residents by checking the care plan or asking a nurse. NA-C stated she was familiar with R2 and it was important to check on her every 30-60 minutes if she was left in her room alone. NA-C stated R2 seldom would take a nap due to her agitation. NA-C stated R2 would sometimes ask to lay down for a while, but said R2 would not usually stay laying down for long. During an interview on 7/27/22, at 2:52 p.m. a RN-B stated R2 was confused and would forget to call for help, and would often get up on her own. RN-B stated staff were to encourage R2 to be in the commons area rather than be alone in her room, but stated "her family likes her to be in her room." R2 stated she felt R2 would be more confused if she had been napping and would often believe she needed to go to the toilet each time she would awake. In response to this, RN-B stated staff would try to keep the door to the room open so they could see R2 when they walked by. RN-B stated a belief that the best thing for R2 was frequent supervision, but said, "family requests her to be in the room so we can't do much about that." During an interview on 7/27/22, at 3:27 p.m. the DON stated new interventions were always added to resident care plans after a fall. DON also stated that was how staff knew how to care for residents was by reading the care plan, but no	F 689		

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F 689	Continued From page 12	F 689		

other mechanism was currently in place to notify staff of changes in the care plan. DON stated families that may be resistant to having residents brought to an area where they can be more easily supervised should receive safety education from the nurses.

On 7/28/22, at 9:24 a.m. R2 was not in any facility common area and could not be seen in her room. RN-A was notified and went to seek out R2's location. After a few minutes, RN-A was observed to find R2 seated on the toilet in her bathroom with a piece of lift equipment parked in front of her with the brakes on. R2 stated she was finished in the bathroom, but the call-light was not observed to have been turned on. RN-A turned on the call-light and then used a walkie-talkie to call NA-A to assist R2 from the toilet.

During an interview on 7/28/22, at 9:33 a.m. NA-A stated R2 was able to transfer with a stand-aid and minimal assist. NA-A said R2 was able to pull herself up with the equipment, but staff locked the brakes and supervised. NA-A also stated R2 could be left on the toilet unsupervised, and she would pull the cord to the call-light when she was done.

During an interview on 7/28/22, at 9:37 a.m. R2 stated she did not remember much about her falls except that, "everyone tells me I fall." R2 was unable to provide any insight into the reasons for her falls, and stated she was not concerned about falling despite having suffered fractures. R2 was unable to identify anything that could be done to reduce her risk of falls. R2 did say she did not really care to be out in the commons area, but was not able to say why. R2 did not recall ever having gotten up unattended since moving to the

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F 689	Continued From page 13 facility. R2 was not able to demonstrate how to turn on her call-light without prompting during that interview. During an interview on 7/28/22, at 10:54 a.m. RN-A stated nursing staff and aides would know if a resident was a fall risk by looking at a resident's care plan, but did not know if there was any other means of identifying high risk fall individuals. RN-A stated she was aware R2 had a history of falls, but did not find information in the care plan regarding whether R2 could be left alone on the toilet. RN-A stated she did not think it was safe to leave R2 unattended on the toilet, but understood that NA-A had received a call to assist another NA with another resident. RN-A stated NA-A could not know how long he might be away when going to help someone else and said she had not yet gone to talk to NA-A about leaving R2 on the toilet, but was planning to do so. RN-A also stated she was unaware of any facility fall prevention protocols, but as a nurse knew it was important to do frequent checks on residents, make sure they were left with water within reach, make sure they were comfortable or did not have to go to the bathroom prior to leaving them. During an interview on 7/28/22, at 12:29 p.m. the facility administrator stated the IDT met every morning, Monday through Friday to discuss patient care, new admissions, upcoming discharges and any falls that might have occurred. Administrator stated a discussion of a fall was to include a root cause analysis to try to determine what had caused a fall so they could attempt to mitigate any similar risks in the future. Administrator stated some persons were "habitual" fallers, but IDT should review all interventions put in place after the fall to see if	F 689		

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F 689	Continued From page 14 they were helpful, if those interventions should continue or be eliminated and replaced with new and different interventions. Administrator stated an expectation for the nurse manager to take notes at the meetings and then document on the IDT discussion and plan. Administrator stated the facility used an "event record" in the electronic medical record for documentation of falls, and stated there was a section in the "event" where the IDT notes could be documented, but stated an expectation for IDT notes to at least be written in the resident progress notes for continuity of care. Administrator stated they did not have a system by which they formally "closed" an event after an IDT discussion and he was unsure of how quickly fall event records were to be reviewed, but stated an expectation of documentation to occur immediately after an IDT discussion. During an interview on 7/28/22, at 1:33 p.m. DON stated IDT met each Wednesday and that was when falls were reviewed. DON stated they could discuss falls on any day, but Wednesday IDT was when they went through the falls in depth and did a thorough analysis of the event. DON stated the IDT meeting was to be documented in a progress note following the meeting. DON stated this documentation was an expectation of the nurse managers job, and had been communicated to the nurse managers upon hire and during IDT meetings. DON stated on that week both nurse managers were gone and he was responsible to cover their work. DON stated the facility had not been fully utilizing the medical record event form and did not currently have a procedure in place for that. A nurse, the RDCS entered the conversation at that time and stated they were making plans for this, and had identified that the	F 689		

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F 689	Continued From page 15 process of identifying the root cause of incidents was in need of improvement. During an interview on 7/28/22, at 1:54 p.m. a CNP-A stated she was notified of falls, but did not attend IDT. CNP-A stated discussions regarding fall preventions were more informal. CNP-A stated R2 had advanced Parkinson's disease and was prone to falls. CNP-A stated R2 was quite alert and might be oriented enough to perform well on a mental status assessment, but R2 did not have recognition of her limitations or demonstrate knowledge of safety measures that might prevent falls or harm. CNP-A stated a FM had asked if R2 could have a mat on the floor of her room and just allow her to crawl around on it, but CNP-A was not sure if this could be done. CNP-A said statements that the family wanted R2 to be in her room rather than brought to the commons area should be taken in context as they had expressed concerns to CNP-A that R2 was sometimes up in her chair near the nurses' station at night for extended periods and they thought this might actually worsen her sleep cycle. CNP-A stated R2 should not be left unattended in the bathroom, and a mechanical lift should not be left in place in lieu of supervision as it could cause an entanglement risk should R2 attempt to get up on her own. During an interview on 7/28/22, at 3:48 p.m. FM-B was visiting R2. FM-B stated she had been involved in a care conference for R2, and was surprised to be told "no side rails or alarms were allowed due to state law." FM-B also stated she was told by the facility they were unable to provide a lip mattress or a Broda chair for the same reason, but FM-B said R2's hospice provider had made arrangements for these items	F 689		

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F 689	Continued From page 16 to be supplied. FM-B stated she was a nurse and had expressed to the facility her concerns with R2 being left in the common area because R2 would not have a call-light or anyway to obtain assistance if staff were not readily available. FM-B stated understanding of R2's need to be supervised as much as possible to prevent falls. An undated facility policy titled, Integrated Fall Management indicated a fall risk assessment form was to be completed within 48 hours of admission, quarterly and upon significant change of condition. The policy indicated those persons at risk for falls were to have an individualized resident centered care plan developed and the interventions were to be based on the findings of the fall risk assessment. Additional professionals were to be contacted as needed including medical providers, pharmacist and/or therapists. The policy indicated an assessment of the resident was to be made after the fall and appropriate notifications made to family and providers, as well as facility administration. The environment was to be evaluated for contributing factors. The policy indicated the IDT was to review the fall and care plan and initiate additional interventions as needed and document this; however, no further information or guidance was listed on how to accomplish this or as to the frequency or expected time line for completion. No further protocols for fall prevention were outlined in the policy. The IJ was removed on 7/30/22, when the facility removal plan was approved and showed resident assessment had been completed, care plans had been revised, therapy evaluation had been completed for R1 on 7/29/22, with recommendation and majority of staff training/education had been completed. On	F 689		

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F 689	Continued From page 17 8/3/22, at 11:00 a.m. during an on site visit it was verified by observation, interview, and record review that the facility took the following steps: · R1 order for therapy evaluation for Broda chair seating and positioning was ordered 7/29/22. Therapist completed evaluation on 7/29/22, with a recommendation for trial wedge cushion to assist in proper seating while allowing resident to continue self-propel ability when up in chair and decrease risk of un-purposeful transfer attempts to promote increased safety and lower risk of mechanical ground fall. Resident responsible party was informed of evaluation and recommendation. R1 care plan was updated on 7/29/22 with education provided to staff on unit. · R2 staff was re-educated on 7/29/22 and care plan revised to include resident was not to be left unattended on the toilet. .	F 689		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the quality assessment and assurance committee (QAA) developed and/or maintained an appropriate systemic action plan for safety and fall prevention as previously cited in surveys exited 1/7/22 and 2/19/20. This failure to operationalize the facility Quality Program Plan had the potential to affect all 55	F 867	A current QAPI policy is present onsite An Ad HOC QAPI meeting was held on 8/1/22 relating to a PIP for a systemic Fall Management program Falls Management has been an elected facility QAPI targeted PIP Involvement and Engagement of various line level staff and contracted staff has	8/25/22

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 08/03/2022

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

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F 867	Continued From page 18 resident who currently reside at the facility Findings include: When interviewed on 7/28/22, 12:29 p.m. the facility administrator stated an awareness of discussions related to falls occurring in the QAPI meetings, but stated he had not been the person responsible for quality assurance or designing performance improvement projects (PIP's) in the facility. The administrator stated there had been an individual hired specifically to handle QAPI and PIP's, however, that person had recently taken on a new role in the company and they did not have anyone to replace her. Administrator stated he would have to take on that role himself, but the change was recent and he had not done so yet. In relation to falls in the facility, the administrator stated that was the director of nursing's (DON) responsibility. Administrator stated he thought they might have a new PIP related to falls, but was unsure. During an interview on 7/29/22, 7:28 a.m. the DON stated the facility had developed a falls PIP, but said it had not been fully implemented due to changes in staffing. DON stated a person hired to support the QAPI process had been pulled in multiple directions, and now had moved to a totally different position. Additionally, clinical support from the regional office had changed multiple times over the past two years. In relation to QAPI and the implementation of PIP's in the facility, DON said turn over in leadership resulted in the team having to "keep going back to square one." DON expressed an understand that a PIP was to be put in place with the express purpose of creating a systemic improvement. DON stated the front line staff were often the main players in	F 867	been an elected facility QAPI target PIP The facility held QAPI on 8/24/22. The elected facility PIPs are to be expanded and progress toward goals outlined for facility systemic improvement Current and future admitted residents have the ability to be affected if there isn't a systemic approach or awareness to the facility's QAPI program Department Leaders were educated on the importance of having a QAPI Policy, an active QAPI program, and various staff line levels involved for overall facility systemic improvement. The QAPI Committee will audit and evaluate progress towards elected PIP goals monthly for 3 months to ensure improvements are present within elected PIPs and that input from all line levels and contracted staff members is encouraged. The QAPI Committee will evaluate for audit continuation. Administrator/designee is responsible Date Certain: 8/25/22	

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F 867	Continued From page 19 providing for safety and preventing falls, but because many of them were contract staff and busy providing resident cares, they did not attend QAPI meetings, and thus were not able to provide much input of what might work best for the residents. DON stated the QAPI group met monthly, but did not have any subcommittees working on PIP activities between meetings. DON said he had received training to perform his position, but felt he needed further information on the QAPI processes and how to develop and maintain a PIP. When interviewed on 7/29/22, 8:23 a.m. a registered nurse hired as the regional director of clinical services (RDCS) stated she had just started in her position in June of 2022 and was just getting to know the facility. RDCS stated she was planning to spend at least one day per week at the facility and planned to provide more education and support to the DON. RDCS stated she had attended a facility QAPI meeting a few weeks before, and the topic of falls was discussed. RDCS stated falls were "of the biggest risk." RDCS said they had discussed doing rounds in the facility and doing spot checks on persons who are of falls risk, and stated an additional nurse manager was expected to help provide coverage. RDCS stated sustained compliance cannot occur unless the items were repeatedly brought back to QAPI for evaluation until the committee agrees the PIP was met and sustainable. A policy on QAPI was not located.	F 867		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: U4DE11

Dear Administrator:

The above facility was surveyed on July 27, 2022 through August 3, 2022 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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 08/03/2022

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

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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 7/27/22 thru 8/3/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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 be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H51533277C (MN85014), with a deficiency cited with a licensing order issued at STAG 830 AND The following complaint was found to be UNSUBSTANTIATED, however a related licening order was issued at STAG 830.. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The 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		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the quality assessment and assurance committee (QAA) developed and/or maintained an appropriate systemic action plan for safety and fall prevention as previously	2 255	Corrected.	8/25/22

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2 255	Continued From page 3 cited in surveys exited 1/7/22 and 2/19/20. This failure to operationalize the facility Quality Program Plan had the potential to affect all 55 resident who currently reside at the facility Findings include: When interviewed on 7/28/22, 12:29 p.m. the facility administrator stated an awareness of discussions related to falls occurring in the QAPI meetings, but stated he had not been the person responsible for quality assurance or designing performance improvement projects (PIP's) in the facility. The administrator stated there had been an individual hired specifically to handle QAPI and PIP's, however, that person had recently taken on a new role in the company and they did not have anyone to replace her. Administrator stated he would have to take on that role himself, but the change was recent and he had not done so yet. In relation to falls in the facility, the administrator stated that was the director of nursing's (DON) responsibility. Administrator stated he thought they might have a new PIP related to falls, but was unsure. During an interview on 7/29/22, 7:28 a.m. the DON stated the facility had developed a falls PIP, but said it had not been fully implemented due to changes in staffing. DON stated a person hired to support the QAPI process had been pulled in multiple directions, and now had moved to a totally different position. Additionally, clinical support from the regional office had changed multiple times over the past two years. In relation to QAPI and the implementation of PIP's in the facility, DON said turn over in leadership resulted in the team having to "keep going back to square one." DON expressed an understand that a PIP was to be put in place with the express purpose	2 255		

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2 255	Continued From page 4 of creating a systemic improvement. DON stated the front line staff were often the main players in providing for safety and preventing falls, but because many of them were contract staff and busy providing resident cares, they did not attend QAPI meetings, and thus were not able to provide much input of what might work best for the residents. DON stated the QAPI group met monthly, but did not have any subcommittees working on PIP activities between meetings. DON said he had received training to perform his position, but felt he needed further information on the QAPI processes and how to develop and maintain a PIP. When interviewed on 7/29/22, 8:23 a.m. a registered nurse hired as the regional director of clinical services (RDCS) stated she had just started in her position in June of 2022 and was just getting to know the facility. RDCS stated she was planning to spend at least one day per week at the facility and planned to provide more education and support to the DON. RDCS stated she had attended a facility QAPI meeting a few weeks before, and the topic of falls was discussed. RDCS stated falls were "of the biggest risk." RDCS said they had discussed doing rounds in the facility and doing spot checks on persons who are of falls risk, and stated an additional nurse manager was expected to help provide coverage. RDCS stated sustained compliance cannot occur unless the items were repeatedly brought back to QAPI for evaluation until the committee agrees the PIP was met and sustainable. A policy on QAPI was not located. SUGGESTED METHOD OF CORRECTIONS:	2 255		

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2 255	Continued From page 5 The administrator and director of nursing (DON) could review education related to the development of a QAPI program and performance improvement programs (PIPs). The administrator and DON could meet with the current QAPI group to discuss how to utilize the concepts of QAPI utilizing front line and contract staff to support any developed PIPs. The QAPI committee could review and evaluate progress towards PIP goals each month, and revisit previous PIPs periodically to ensure improvement is sustained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 255		
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 comprehensively assess falls and identify causative factors to	2 830	Corrected.	8/25/22

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2 830	Continued From page 6 determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 2 of 3 residents (R1, R2) reviewed for accidents. R1 who had 11 falls, nine falls from a Broda chair with six falls unwitnessed. On 7/10/22 R1 was left alone in her room after placed in her Broda chair, fell and sustained a fracture. On 5/18/22, R2 fell during the night after she got up unattended to go to the bathroom resulting in a fracture. R2 has fallen an additional 14 times; each of the 14 falls occurred in R2 ' s room when alone and unsupervised. These deficient practices resulted in immediate jeopardy. An immediate jeopardy began on 7/11/22 when it was discovered, R1 fell from the Broda chair and sustained a left acetabulum and pubic fracture and was admitted to the hospital. The facility administrator and director of nursing (DON) were notified of the IJ on 7/29/22 at 10:33 a.m. The IJ was removed effective 7/30/22 when the facility revised residents care plan, completed therapy evaluation and provided staff training, but noncompliance remained at the lower scope and severity level 2- 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: R1's significant change Minimum Data Set (MDS) assessment dated 7/14/22, indicated R1 had more than two falls and one resulted in a major injury, R1 is severely cognitively impaired and needs extensive assist of 2 persons for bed mobility and transfers and did not walk during the assessment period. The MDS indicated use of a wheelchair for mobility and transfers. R1's MDS	2 830		

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2 830	Continued From page 7 further indicated R1 was incontinent of bowel and bladder and currently on hospice. R1's care plan interventions dated 4/11/21, include: keep call light in reach, provide assist of 2 with lift for toileting. R1's care plan dated 3/10/21 indicates R1 cannot verbally ask for assistance and requires 2 assist to use the bathroom. In addition, R1's care plan included, R1 to remain in common area until ready for bed. R1 also has a history of falls related to muscle weakness, dementia with Lewy bodies and behaviors. R1's care plan goal was not to sustain a fall with injury through the review date. Furthermore, R1's care plan also included frequently check in room at least 1-2 hours or as needed, instruct staff to follow the same routine each day and to analyze resident's falls and follow fall policy. During an observation on 7/28/22, at 9:40 a.m. R1 was seated in the Broda chair by the nurses station, no table and no activities provided. R1 staring blankly at the wall or window. R1's record review indicated previous falls: R1 had 2 falls on 1/11/22. First fall- R1 was found after she had fallen from her recliner and the second fall that day R1 fell from her Broda in the common area. R1's fall documentation for incidents occurring on 3/25/22, 3/28/22 and 3/31/22, indicated R1 fell from the Broda chair because she was unfamiliar with the Broda chair. R1 since received her personal Broda chair and no further falls from the Broda chair had occurred. The facility documentation lacked an identification of causative factor, an analysis of why R1 continued to get up from the Broda and had not placed effective interventions to prevent	2 830		

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2 830	Continued From page 8 future falls. R1's fall event report dated 5/16/22 includes, Housekeeping staff notified writer resident was sitting on the floor at 3:20 p.m. Writer noted resident to be sitting on the floor at the nurse station by a table, she was sitting with her legs tucked under her, trying to stand herself up. Resident was wearing shoes at the time, but noted a pair of shoes to be under the table that it seemed resident was reaching for and either stood herself up or bent forward and slid out. Immediate intervention: staff will remove any items (shoes, etc) from the floor around resident to prevent her from reaching for them. She was toileted about 35 minutes prior to this. R1 was screened by therapy three days later (5/19/22) with no services indicated. R1's fall event report dated 5/19/22 includes, Resident attempted to stand up on her own and ended up falling on the floor on her bottom. Fall was witnessed. Resident was in common area by nursing station after lunch. Had been given activities and seen 30 seconds prior by multiple staff. R1 was screened by therapy 14 days later (6/2/22) with no services indicated. R1's fall event report dated 6/5/22 includes, Resident had an unwitnessed fall in room late this afternoon. Resident had just been toileted and had her clothes changed by aides. Resident was left in room watching TV in her Broda chair. Aides stated she left room to assist with something and came back and resident was on the floor. Resident had one sock on and one sock off. Resident took out a drawer from a cabinet and sat in it. Resident was lifted with Hoyer back into her Broda chair with the assistance of two aides and brought out to common area.	2 830		

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	00419	A. BUILDING: _____ B. WING _____	C 08/03/2022

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2 830	Continued From page 9 Events 5/16/22, 5/19/22 and 6/5/22, were reviewed and closed on 7/7/22 by facility interdisciplinary team (IDT). The review note includes, "On 5/16 resident had an unwitnessed fall by the nurses station. She was attempting to pick up shoes off the floor. No injuries noted. On 5/19, resident had a witnessed fall by the nurses station. No injuries noted. On 6/5, resident had an unwitnessed fall in her room while sitting in her Broda chair. Resident is at risk for falls d/t [due to] prescribed antidepressant medication with dx [diagnosis] of depression, melatonin with a dx of insomnia, HTN [hypertension] with prescribed antihypertensive medication and most recent BIMS [brief interview for mental status] of 0 indicating severe cognitive impairment. RCA[root cause analysis]: poor safety awareness. Interventions include: Ensure floor is free from clutter in residents surroundings, Offer the toilet resident upon arising, before and/or after meals at HS[bedtime] and prn[as needed] and do [sic] leave resident unattended in Broda chair in her room. R1's care plan lacked the interventions discussed in the IDT meeting. During an interview on 7/27/22, at 1:56 p.m. trained medication assistant (TMA)-A stated he felt everyone knew R1 should be brought to the common area and should not be left alone in R1's room. TMA-A stated he looks in the care guide for fall interventions for all residents in the facility. During an interview on 7/27/22, at 2:06 p.m. TMA-B stated she worked on 7/11/22, the day after R1's fall with major injury. TMA-B stated staff usually toilet R1 after getting her up and then R1 is brought to common room. TMA-B stated R1	2 830		

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2 830	Continued From page 10 should not have been alone in her room on 7/10/22. During an interview on 7/27/22, at 2:20 p.m. nursing assistant (NA)-B stated he observed R1 on the floor in her room on 7/10/22 and called to the nurse. NA-B stated he had seen her previously in her Broda chair after breakfast . NA-B stated, "Everybody knows not to leave her in her room because she will get up. I was surprised to see her alone in her room." During an interview on 7/27/22, at 2:26 p.m. registered nurse (RN)-B who is familiar with R1 and takes care of her one or two times a week. RN-B was aware of R1's fall with injury. RN-B added the reason for the fall was because R1 was left alone in her room. RN-B stated she believed a night shift staff had gotten her up and left R1 in her room alone. RN-B stated she would not leave R1 alone in her room if she is awake unless requested to do so by hospice or a visitor. During an interview on 7/27/22, at 2:38 p.m. director of nursing (DON) stated the expectation is all staff are to know the interventions and ways of caring for the residents. Resident interventions for falls are in the care plan. During an interview on 7/27/22, at 3:20 p.m. licensed practical nurse (LPN)-A stated she was R1's nurse at the time of the fall on 7/10/22. LPN-A stated she was not aware of R1 being alone in her room in the chair prior to the fall. LPN-A stated if R1 is in her chair she keeps her up near the nurses station. LPN-A stated she was not aware of the intervention indicating R1 is not to be left alone in her room. LPN-A said she was aware there was a sign above R1's bed that read she should not be left in her room alone. LPN-A	2 830		

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2 830	Continued From page 11 was not aware when the sign was hung in R1's room. LPN-A said she was not aware of any interventions added to the care plan after R1's fall on 7/10/22. During an interview on 7/28/22, at 1:55 p.m. certified nurse practitioner (CNP)-A stated facility staff contacts her after a fall. CNP-A stated R1 is a challenge and feels the facility is attempting to prevent further falls. CNP-A even has prevented R1 from falling when walking by the nurses station. CNP-A stated she did feel the Broda chair is appropriate and the best seating option for R1. During an interview on 7/28/22, at 2:41 p.m. occupational therapy (OT) verified R1 was last on caseload April 15 th to May 6th, 2022 related to impairments in transfers. OT had last seen her January 13th of 2021. OT indicated R1 had not evaluated a wheelchair or Broda chair. During an interview on 7/28/22, at 4:08 p.m. DON stated the facility does not have a current audit process in place to monitor the effectiveness of interventions placed in the care plan. DON indicated the facility uses general observations exampled by; if a resident moves to a new room and it is observed the resident had non skid strips on the floor and or grab bars on the bed, they are moved or installed in the new room. Interventions in the computer are monitored by audits such as the tasks the nurses complete. DON stated if the interventions are not on the care plan he said, "it doesn't matter how good it is". Once the IDT are completed with the review and interventions they should be placed in the care plan right away. DON verified if the interventions are not in the care plan staff are not aware of any new interventions developed. The	2 830		

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2 830	Continued From page 12 DON's expectation after the IDT meeting would have been for the nurse manager to place the discussed interventions in the care plan related to R1's falls. During an interview on 7/29/22, at 8:24 p.m. regional director clinical services (RDCS) stated she had met with quality assurance performance improvement (QAPI) and talked about fall management program and was currently working with a consultant from Pathways. She stated they are working on falls and working on investigations. RDCS indicated quality assurance improvement program meeting had lots of falls discussed and improving the IDT process including investigations. RDCS added her expectations would be to have falls brought to quality assurance and audits should continue to be addressed until compliance is met. Adding, falls are one of the biggest risks. When asked about the closing of the event reports after an incident she said, "The closing of the falls event needs to look at closer as a process, there are currently no standard in this building. The goal is with in one week I would say is reasonably." R2 R2's significant change MDS assessment dated 6/28/22 indicated R2 had cognitive impairment, Parkinson's disease with dementia, and suffered from anxiety. The MDS indicated R2 required the regular use of an anti-psychotic and anti-depressant medication. The MDS also indicated R2 required the extensive assistance of 1-2 persons with bed mobility, transfers and ambulation, as well as with dressing, grooming and toileting. MDS also indicated R2 suffered from falls and was recovering from a fracture related to a fall.	2 830		

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2 830	Continued From page 13 R2's progress notes indicated R2 had been admitted to the facility in April of 2022 for rehabilitation services with the goal of returning to assisted living after a fall that required hospitalization. R2's care plan included a problem list initiated 5/5/22 and updated 7/11/22 indicating, "Resident is at high risk for falling due to multiple pelvic fx, h/o [history of] falling, Parkinson's disease, weakness, poor vision, frequency of micturition [urination], altered mental status, impaired mobility. Fall risk evaluation score indicates high risk for falls." Interventions included, "fall prevention/reduction precautions per facility protocol," and "toileting per urinary/bowel section of this care plan." The intervention in that section of the care plan indicated, "offer toileting in AM upon arising, before and after meals, at HS [bedtime] and with nightly rounds." R2's medical record indicated R2 suffered 14 incidents where she fell or ended up on the floor. On 5/18/22, R2 was found on the floor in her bathroom at around 2:30 a.m. According to a progress note, R2 stated she wanted to go to the emergency department (ED). Subsequently, the facility received a call from the hospital to let them know R2 would be returning to the facility later in the day, and R2 had suffered a left femur fracture subsequent to the fall, but would not require surgical intervention. R2 had reported hitting her head when she fell and suffered a hematoma (collection of blood outside of the blood vessels) injury. R2's medical record events (incident reports) and progress notes lacked evidence showing analysis was done to identify the root cause of R2's falls.	2 830		

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2 830	Continued From page 14 R2's care plan fall interventions lacked fall prevention interventions. In addition, despite the 5/18/22 fall having occurred in the bathroom, the facility failed to add new intervention timely. The next update to R2's fall care plan was placed on 5/23/22 and indicated the room had been rearranged to R2's preference. In relations to subsequent falls, interventions were added including, "5/27/22, bed in low position with fall mat at bedside," "5/31/22, have resident in commons area when awake as she will allow," "6/27/22, bring resident to the nurses' station after meals until staff can toilet resident-do not bring her to her room after meals unless she can be toileted right away," "6/27/22, assist resident with toileting every 2-3 hours and as needed per her request" and on "7/7/22, staff will complete 30 minute safety checks on resident any time she is in her room without family present. Continue to encourage her to sit at station between meals as she is willing." During an observation and interview 7/27/22, at 12:55 p.m. R2 was observed in her room seated in a reclining Broda chair. R2 had a family member (FM)-A visiting. FM-A stated he was aware R2 fell frequently. FM-A stated he felt R2 was likely to continue to fall due to her Parkinson's and the length of facility halls and the time it would take any person to walk to R2's room. During an interview on 7/27/22, at 2:39 p.m. R2 was not oriented to the time of day. R2 stated she was aware she was prone to fall, but was unable to state anything about the falls, when or why she had fallen. During an interview on 7/27/22, at 2:44 p.m. a NA-B stated staff knew how to take care of any	2 830		

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2 830	Continued From page 15 resident by looking at their care plan. NA-B stated fall prevention interventions in general included making sure residents are always left in a safe place, and were positioned appropriately. During an interview on 7/27/22, at 2:46 p.m. NA-C stated staff would know how to care for residents by checking the care plan or asking a nurse. NA-C stated she was familiar with R2 and it was important to check on her every 30-60 minutes if she was left in her room alone. NA-C stated R2 seldom would take a nap due to her agitation. NA-C stated R2 would sometimes ask to lay down for a while, but said R2 would not usually stay laying down for long. During an interview on 7/27/22, at 2:52 p.m. a RN-B stated R2 was confused and would forget to call for help, and would often get up on her own. RN-B stated staff were to encourage R2 to be in the commons area rather than be alone in her room, but stated "her family likes her to be in her room." R2 stated she felt R2 would be more confused if she had been napping and would often believe she needed to go to the toilet each time she would awake. In response to this, RN-B stated staff would try to keep the door to the room open so they could see R2 when they walked by. RN-B stated a belief that the best thing for R2 was frequent supervision, but said, "family requests her to be in the room so we can't do much about that." During an interview on 7/27/22, at 3:27 p.m. the DON stated new interventions were always added to resident care plans after a fall. DON also stated that was how staff knew how to care for residents was by reading the care plan, but no other mechanism was currently in place to notify staff of changes in the care plan. DON stated	2 830		

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2 830	Continued From page 16 families that may be resistant to having residents brought to an area where they can be more easily supervised should receive safety education from the nurses. On 7/28/22, at 9:24 a.m. R2 was not in any facility common area and could not be seen in her room. RN-A was notified and went to seek out R2's location. After a few minutes, RN-A was observed to find R2 seated on the toilet in her bathroom with a piece of lift equipment parked in front of her with the brakes on. R2 stated she was finished in the bathroom, but the call-light was not observed to have been turned on. RN-A turned on the call-light and then used a walkie-talkie to call NA-A to assist R2 from the toilet. During an interview on 7/28/22, at 9:33 a.m. NA-A stated R2 was able to transfer with a stand-aid and minimal assist. NA-A said R2 was able to pull herself up with the equipment, but staff locked the brakes and supervised. NA-A also stated R2 could be left on the toilet unsupervised, and she would pull the cord to the call-light when she was done. During an interview on 7/28/22, at 9:37 a.m. R2 stated she did not remember much about her falls except that, "everyone tells me I fall." R2 was unable to provide any insight into the reasons for her falls, and stated she was not concerned about falling despite having suffered fractures. R2 was unable to identify anything that could be done to reduce her risk of falls. R2 did say she did not really care to be out in the commons area, but was not able to say why. R2 did not recall ever having gotten up unattended since moving to the facility. R2 was not able to demonstrate how to turn on her call-light without prompting during that interview.	2 830		

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2 830	Continued From page 17 During an interview on 7/28/22, at 10:54 a.m. RN-A stated nursing staff and aides would know if a resident was a fall risk by looking at a resident's care plan, but did not know if there was any other means of identifying high risk fall individuals. RN-A stated she was aware R2 had a history of falls, but did not find information in the care plan regarding whether R2 could be left alone on the toilet. RN-A stated she did not think it was safe to leave R2 unattended on the toilet, but understood that NA-A had received a call to assist another NA with another resident. RN-A stated NA-A could not know how long he might be away when going to help someone else and said she had not yet gone to talk to NA-A about leaving R2 on the toilet, but was planning to do so. RN-A also stated she was unaware of any facility fall prevention protocols, but as a nurse knew it was important to do frequent checks on residents, make sure they were left with water within reach, make sure they were comfortable or did not have to go to the bathroom prior to leaving them. During an interview on 7/28/22, at 12:29 p.m. the facility administrator stated the IDT met every morning, Monday through Friday to discuss patient care, new admissions, upcoming discharges and any falls that might have occurred. Administrator stated a discussion of a fall was to include a root cause analysis to try to determine what had caused a fall so they could attempt to mitigate any similar risks in the future. Administrator stated some persons were "habitual" fallers, but IDT should review all interventions put in place after the fall to see if they were helpful, if those interventions should continue or be eliminated and replaced with new and different interventions. Administrator stated an expectation for the nurse manager to take	2 830		

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2 830	Continued From page 18 notes at the meetings and then document on the IDT discussion and plan. Administrator stated the facility used an "event record" in the electronic medical record for documentation of falls, and stated there was a section in the "event" where the IDT notes could be documented, but stated an expectation for IDT notes to at least be written in the resident progress notes for continuity of care. Administrator stated they did not have a system by which they formally "closed" an event after an IDT discussion and he was unsure of how quickly fall event records were to be reviewed, but stated an expectation of documentation to occur immediately after an IDT discussion. During an interview on 7/28/22, at 1:33 p.m. DON stated IDT met each Wednesday and that was when falls were reviewed. DON stated they could discuss falls on any day, but Wednesday IDT was when they went through the falls in depth and did a thorough analysis of the event. DON stated the IDT meeting was to be documented in a progress note following the meeting. DON stated this documentation was an expectation of the nurse managers job, and had been communicated to the nurse managers upon hire and during IDT meetings. DON stated on that week both nurse managers were gone and he was responsible to cover their work. DON stated the facility had not been fully utilizing the medical record event form and did not currently have a procedure in place for that. A nurse, the RDCS entered the conversation at that time and stated they were making plans for this, and had identified that the process of identifying the root cause of incidents was in need of improvement. During an interview on 7/28/22, at 1:54 p.m. a CNP-A stated she was notified of falls, but did not	2 830		

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2 830	Continued From page 19 attend IDT. CNP-A stated discussions regarding fall preventions were more informal. CNP-A stated R2 had advanced Parkinson's disease and was prone to falls. CNP-A stated R2 was quite alert and might be oriented enough to perform well on a mental status assessment, but R2 did not have recognition of her limitations or demonstrate knowledge of safety measures that might prevent falls or harm. CNP-A stated a FM had asked if R2 could have a mat on the floor of her room and just allow her to crawl around on it, but CNP-A was not sure if this could be done. CNP-A said statements that the family wanted R2 to be in her room rather than brought to the commons area should be taken in context as they had expressed concerns to CNP-A that R2 was sometimes up in her chair near the nurses' station at night for extended periods and they thought this might actually worsen her sleep cycle. CNP-A stated R2 should not be left unattended in the bathroom, and a mechanical lift should not be left in place in lieu of supervision as it could cause an entanglement risk should R2 attempt to get up on her own. During an interview on 7/28/22, at 3:48 p.m. FM-B was visiting R2. FM-B stated she had been involved in a care conference for R2, and was surprised to be told "no side rails or alarms were allowed due to state law." FM-B also stated she was told by the facility they were unable to provide a lip mattress or a Broda chair for the same reason, but FM-B said R2's hospice provider had made arrangements for these items to be supplied. FM-B stated she was a nurse and had expressed to the facility her concerns with R2 being left in the common area because R2 would not have a call-light or anyway to obtain assistance if staff were not readily available. FM-B stated understanding of R2's need to be	2 830		

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2 830	Continued From page 20 supervised as much as possible to prevent falls. An undated facility policy titled, Integrated Fall Management indicated a fall risk assessment form was to be completed within 48 hours of admission, quarterly and upon significant change of condition. The policy indicated those persons at risk for falls were to have an individualized resident centered care plan developed and the interventions were to be based on the findings of the fall risk assessment. Additional professionals were to be contacted as needed including medical providers, pharmacist and/or therapists. The policy indicated an assessment of the resident was to be made after the fall and appropriate notifications made to family and providers, as well as facility administration. The environment was to be evaluated for contributing factors. The policy indicated the IDT was to review the fall and care plan and initiate additional interventions as needed and document this; however, no further information or guidance was listed on how to accomplish this or as to the frequency or expected time line for completion. No further protocols for fall prevention were outlined in the policy. The IJ was removed on 7/30/22, when the facility removal plan was approved and showed resident assessment had been completed, care plans had been revised, therapy evaluation had been completed for R1 on 7/29/22, with recommendation and majority of staff training/education had been completed. On 8/3/22, at 11:00 a.m. during an on site visit it was verified by observation, interview, and record review that the facility took the following steps: · R1 order for therapy evaluation for Broda chair seating and positioning was ordered 7/29/22. Therapist completed evaluation on 7/29/22, with a	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 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 21 recommendation for trial wedge cushion to assist in proper seating while allowing resident to continue self-propel ability when up in chair and decrease risk of un-purposeful transfer attempts to promote increased safety and lower risk of mechanical ground fall. Resident responsible party was informed of evaluation and recommendation. R1 care plan was updated on 7/29/22 with education provided to staff on unit. · R2 staff was re-educated on 7/29/22 and care plan revised to include resident was not to be left unattended on the toilet. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could educate team members on how to identify an incident's root cause. DON or designee could review/audit event/incicent documents to be sure that adequate root-cause analysis has been completed for all falls in order to ensure a relevant intervention has been initiated to prevent future incidents. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		