Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 25, 2024

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

RE: CCN: 245153
Cycle Start Date: December 28, 2023

Dear Administrator:

On January 19, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

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January 25, 2024

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

Re: Reinspection Results
Event ID: GLFC12

Dear Administrator:

On January 19, 2024 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 December 28, 2023. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 5, 2024

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

RE: CCN: 245153
Cycle Start Date: December 28, 2023

Dear Administrator:

On December 28, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 28, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 28, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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

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January 5, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: GLFC11

Dear Administrator:

The above facility was surveyed on December 27, 2023 through December 28, 2023 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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
	245153	A. BUILDING ______ B. WING ______	C 12/28/2023

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 12/27/23 and 12/28/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51538070C (MN00099333) with a deficiency cited at F684 and F623. 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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		1/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 01/15/2024

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 623	Continued From page 1	F 623		

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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F 623	Continued From page 2	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 3 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident and/or resident representative (RR) with a written notice of facility initiated transfer for 1 of 1 resident (R1) reviewed for hospitalization. Findings include: R1's face sheet included diagnoses of fracture of neck of left femur, chronic systolic heart failure, vascular dementia, muscle weakness, difficulty walking, long term use of anticoagulants, cognitive communication deficit. R1's progress note dated 12/15/23 at 6:33 p.m. indicated R1 had a fall and was on anticoagulation medication. He was transferred to the hospital for further evaluation. R1 returned to the facility at 6:45 p.m. In review of R1's record, it was not evident R1 and/or R1's resident representative was provided with a written transfer notice. During an interview on 12/28/2023, 2:40 p.m. regional director of clinical services (RDCS) reviewed R1's record and stated the facility completed the bed hold notice but did not complete a transfer notice. RDCS stated she was not aware of the regulation or requirement of transfer forms in the nursing home.	F 623	R1 no longer resides at the facility. All other residents have the ability to be affected by this deficient practice. All facility-initiated transfers from the last 30 days prior to 1/10/24 have been reviewed for compliance and post transfer forms have been filled out for them if missed. Progress notes reviewed and all residents and their representatives were notified of their transfer. The facility reviewed the Emergency Transfer and Discharge Policy and no revisions were made. A facility initiated transfer form was provided for use. Facility nurses to receive education regarding the Emergency Transfer and Discharge Policy. A checklist was created to be sure that all documents needing to be completed for a transfer to the hospital are done. All nurses will be educated by 1/17/24. The Social Worker or designee will complete audits of all facility initiated transfers for 4 weeks for compliance. Results of the audits will be reported at Quality Council with ongoing frequency and duration determined through analysis and review of results if substantial	

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F 623	Continued From page 4 During an interview on 12/28/23 at 2:45 p.m., the director of nursing (DON) stated the nurses were expected to notify the resident or representative verbally about the reason for emergent transfers and was unsure of a process for written notice. The facility policy titled Emergency Transfer and Discharge dated 02/19, identified should it be necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will prepare a transfer form to send with the resident.	F 623	compliance is not met.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete neurological assessments and comprehensively assess and monitor skin injuries following falls for 4 of 4 residents (R1, R2, R3, R4) who had unwitnessed falls or unwitnessed falls with injuries. Findings include: R4's face sheet included diagnoses of trochanteric bursitis, left hip, type 2 diabetes mellitus with diabetic nephropathy, age related	F 684	R1 no longer resides at facility. R2 wrist wounds were assessed on 12/21/23 and had resolved. R3 had a comprehensive assessment on 1/11/24 with no abnormal findings from baseline. Bruises to legs and arms are now resolved. R4 had a comprehensive assessment on 1/11/24 with no abnormal findings from	1/15/24

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F 684

Continued From page 5

osteoporosis without current pathological fracture, mild neurocognitive disorder, history of falling.

R4's admission Minimum Data Set (MDS) dated 10/10/23, indicated R4 was cognitively intact, was dependent on staff for lower body dressing, was substantial to max assistance from staff for hygiene, and was partial to moderate assist from staff for toileting, mobility, and transfers. MDS also indicated R4 had a fall in the last month and another in the last 2-6 months.

R4's Safety Events report-Falls dated 10/26/23, indicated R4 had an unwitnessed fall at 7:05 p.m., that resulted in a bump on the head (no location of bump on the head was identified) and was sent to the emergency room (ER). Treatment included monitor for 72hours for bruising, change in mental status/condition, pain or other injuries related to fall. Neuro checks for every 15 minutes-times 4, then every hour- times 2, then every 2 hours- times 2, then every 4 hours- times 2, then every shift- times 3. Post fall observation every shift- times 9 to equal 72 hours.

R4's progress note dated 10/26/23, at 10:55 p.m. indicated R4 arrived back at the facility.

R4's physician visit note dated 10/27/23, indicated R4 was seen by the physician for post fall follow-up. The note did not address R4's injury to her head. Note directed staff to continue with neuro and vital sign monitoring.

R4's follow up vital signs and neuro checks sheet initiated on 10/26/23, indicated R4 was at the hospital till 8:00 p.m., on 10/26/23. R4's neuro checks did not resume until midnight on 10/27/23 then checked again on 10/27/23 at 4:00 a.m. On

F 684

baseline. Vitals have been within baseline and no further issues noted. Bump to forehead continues to be followed by wound nurse weekly.

All other residents who experience a fall while in the facility have the potential to be affected by this deficient practice. All residents that have experienced a fall in the facility within the past 30 days will have a post-fall assessment completed by the facility wound nurse/DON to ensure that any injuries obtained during the fall have healed appropriately or are being monitored.

The fall management and neurological check policy were reviewed with no revisions made.

Education completed with nursing staff on falls policy and procedure and neurological check process as well as education on proper skin assessments following a fall. All nurses to be educated by 1/17/24.

The DON or designee will complete audits on up to 3 residents that fall per week x 4 weeks and then up to 2 residents that fall per week x 4 weeks. Results of audits will be reported at the Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 6	F 684		

10/27/23, 10/28/23, and 10/29/23, there were two other entries marked as AM and PM but no time was specified when the neuro assessments were completed.

In review of R4's record it was not evident vital signs were monitored in conjunction with neuro assessments, nor a comprehensive assessment of head bump was completed, nor evident R4's head injury was continuously monitored following the incident on 10/26/23.

R4's progress note dated 12/5/23 at 11:49 p.m., indicated R4 was found on the floor at 11:35 p.m. bleeding from left forehead. Resident was sent to ER. R4 returned to the facility at 4:28 a.m. with a visible wound on the left eyebrow and lump on her forehead. No further description of the head wound was included.

R4's progress note from 12/6/23, at 8:03 a.m. indicated R4 was in her recliner and had a dressing on her forehead, no active bleeding. No further description was included.

R4's skin assessment dated 12/6/23, included a diagram of a body. The front (face) had a circle drawn on the forehead with the words "Bump on forehead" written next to the circle. On the back of the diagram there was a circle on the middle of the back of the head with words "Bumps on head" written next to the circle. No other description of wound was included.

Subsequent skin assessments were completed on 12/14/23 and 12/19/23, however, did not address R4's head wound. In review of R4's record it was not evident the injury to R4's head was comprehensively assessed and continuously

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 12/28/2023

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 684	Continued From page 7	F 684		

monitored falling the fall on 12/5/23.

R4's progress note dated 12/20/23 at 8:33 a.m. indicated R4 had an unwitnessed fall and was found on the floor "hitting left forehead, L [left] forehead has a big bump with actively bleeding." R4 stated "my head is very sore and pian" The note indicated R4 was sent to the ER for further evaluation. No further description of the injury was included. Subsequent progress note at 2:18 p.m. included, "she [R4] continues to have bruising on her face and bandage on her forward [sic]" The progress note had no further description of the bruising or injury the bandage covered.

Skin assessment dated 12/21/23 and 12/27/23, did not identify the injury to R4's head. In review of R4's record it was not evident the injury to R4's head was comprehensively assessed and continuously monitored falling the fall on 12/20/23.

During an observation on 12/28/23 at 10:51 a.m., R4 sitting in her wheelchair participating in an activity. R4 had a large bandage on her forehead.

R2's face sheet included diagnoses of Parkinson's disease without dyskinesia, Alzheimer's disease, history of falling, and abnormalities of gait and mobility.

R2's quarterly MDS dated 10/30/23, indicated R2 had moderate cognitive impairment. R2 required partial to moderate assistance with dressing, bathing, toilet hygiene, and transfers. MDS identified no fall since re-admission on 7/24/23.

R2's Event report dated 11/5/23 at 1:50 p.m.,

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 12/28/2023

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F 684	Continued From page 8	F 684		

indicated R2 was lowered to the floor while toileting by NA. R2 sustained a skin tear to each wrist. On the left wrist skin tear measured 5.5 centimeter (cm) by 3.0 cm and on right wrist skin tear measured 2.0 cm by 2.0 cm. Area cleaned and covered with non-stick gauze. New treatment initiated to cleanse wound with soap and apply clean dressing change as needed. Xeroform gauze to be applied over the entire lacerated area then covered with 4 by 4 gauze and secured in place with roller gauze.

In review of R2's record between 11/5/23 and 12/28/23, it was not evident the wrist wounds were assessed weekly and continuously monitored. R2's record included the following; R2's weekly skin checks completed on 11/9/23, 11/17/23, 11/20/23 did not address R2's injuries to her wrists.

R2's event report dated 11/22/23 at 6:31 p.m., indicated left arm wound sustained from fall is not healed and sanguineous drainage noted in the old dressing. No further description of the wound was included.

R2's skin audit dated 11/24/23, included no new skin changes and did not address injuries to R2's wrist.

R2's skin audit dated 12/4/23, identified R2 had sore on left wrist, redness on her right shoulder and small bruises on both arms. The note did not include any further descriptions of impaired skin integrity.

R2's progress note dated 12/8/23, indicated weekly skin assessment completed with no new injuries. The note did not identify the injuries to

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	245153	A. BUILDING ______ B. WING ______	C 12/28/2023

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 684	Continued From page 9 R2's wrist. R2's skin audit dated 12/14/23, indicated R4 refused to take shower skin check not completed. R2's skin audit dated 12/15/23 and 12/25/23, did not address R2's wrist injuries. During on observation on 12/27/23, at 3:51 p.m. R2's left wrist had a thin reddish/pink line with no open areas and had minimal bruising to both arms in various stages of healing. During an interview on 12/28/23, at 10:02 a.m., case manager (CM)-A reviewed R2's record and stated R2's wrist skin tears should have been documented on in the providers notes and in the progress notes. If it wasn't in the progress notes, it wasn't done. R3's face sheet included diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), diabetes mellitus with diabetic chronic kidney disease, history of falling, unsteadiness on feet, and difficulty in walking. R3's quarterly MDS dated 11/22/23, indicated R3 had severe cognitive impairment. R3 was dependent on staff for bathing and bathing transfers, R3 did not walk, R3 required substantial to maximal assistance for transfers and dressing. R3's Safety Events Falls dated 10/27/23, identified R3 had an unwitnessed fall at 4:31 p.m. and was unable to explain why she fell. The report did not identify if R3 sustained injuries as a result of the fall.	F 684		

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	245153	A. BUILDING ______ B. WING ______	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 10	F 684		

In review of R3's record it was not evident neurological assessments were completed and not evident skin assessment was completed immediately following the fall. R3's skin audit dated 11/1/23, identified R3 had bruises to his legs and arms, however, did not include any further description and did not identify causation of the bruises.

R3's Safety Events Falls dated 11/25/23, identified R3 had an unwitnessed fall at 9:30 a.m. She was found sitting on the floor between bed and wheelchair.

In review of R3's record it was not evident neurological assessments were completed after the unwitnessed fall and not evident a skin assessment was completed immediately following the fall.

R3's Safety Events Falls dated 12/19/23 at 6:52 a.m., identified R3 had an unwitnessed fall, she was found outside her room in a seated position. R3 reported she had lost her balance, fell, and did not hit her head. A skin check was done, and no injury was noted. Neuro checks started.

R3's follow-up vital signs and neuro checks document included neuro checks on 12/19/23. The first recorded neurological check was recorded at 10:00 a.m. and had multiple missing entries when neurological assessments were supposed to be completed. The last entry was recorded on 12/22/23 at 1:00 p.m.

R3's skin assessments were reviewed between 11/8/23 and 12/27/23. Skin assessment dated 12/27/23, indicated R3 had old skin bruises and a scab on left leg. However, the skin evaluations

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 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 11	F 684		

dated 11/8/23, 11/15/23, 11/21/23, 11/22/23, 11/29/23, and 12/13/23 did not identify R3 had any bruising and/or a scab on left leg. Additionally, the record did not identify when or how R3 sustained bruises that were described as "old" on the 12/27/23 assessment.

R1's face sheet included diagnoses of fracture of neck of left femur, chronic systolic heart failure, vascular dementia, muscle weakness, difficulty walking, long term use of anticoagulants, and cognitive communication deficit.

R1's progress note dated 12/15/23 at 6:33 p.m., indicated R1 had an unwitnessed fall and was found on the floor laying on his right side around 12:30 p.m. R1 stated she fell forward out of his recliner. R1 was sent to ER related to being on anticoagulant and returned at 6:45 p.m.

R1's progress note dated 12/16/23, at 5:23 a.m., indicated R1 had an unwitnessed fall at 5:00 a.m. R1 was found sitting on the floor beside his bed. R1 denied hitting his head and had pain in right leg.

R1's progress note dated 12/16/23, 6:38 a.m., indicated R1 wanted to go to the hospital and was transferred to the hospital at 6:34 a.m.

In review of R1's record it was not evident neurological assessments were initiated and completed after R1's falls on 12/15/23 and 12/16/23.

During an interview on 12/27/23 at 11:02 a.m., registered nurse (RN)-B stated after resident falls the floor nurse assigned to the resident gathered all the information. The nurse then provided the

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 12/28/2023

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 684	Continued From page 12 information to the clinical managers. RN-B indicated nurses were supposed to complete and document skin inspections after each fall. Floor nurses completed weekly skin audits and would only report new or worsening skin problems to the clinical managers. RN-B stated she has never measured or documented wound assessments and when she did wound dressing changes she would not document wound descriptions or measurements. During an interview on 12/28/23, at 11:04 a.m. RN-C stated if a fall was unwitnessed, the floor nurse should initiate neuro checks and assess for injury. Facility fall protocol directed staff take vital signs every shift for 72- hours. If a wound was found RN-C would inform the wound nurse or providers. Measuring of all wounds should be done during wound rounds by the team or wound nurse. RN-C had only completed comprehensive wound assessments and measurements on new wounds and did not complete weekly assessments and measurements for existing wounds. During an interview on 12/27/23 at 9:48 a.m., clinical manager (CM)-B stated neuro checks were supposed to be completed after any unwitnessed fall or a fall with head injury. CM-B indicated there was a fall check list that needed to be initiated after a fall and turned into the clinical managers once completed. During an interview on 12/28/23, at 10:02 a.m., CM-A explained when a wound was found, the floor nurse would document the wound on the wound sheet and in a progress note. Existing skin tears were supposed to be monitored and documented on weekly on the wound	F 684		

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F 684	Continued From page 13	F 684		

assessments and in a progress note. The documentation should also include if the wound was new, worsened, or if resolved. If the wound was diabetic, venous, arterial, pressure, or surgical the wound nurse and provider would follow them until resolution, but they did not follow other types of impaired skin integrity.

During an interview on 12/28/23 at 11:40 a.m., director of nursing (DON) stated, expectations for new wounds following a fall would be to monitor the wound after and chart on it every shift for 3 days. The case managers were responsible for ensuring this was completed by the floor nurses. Any wound even if a bruise should be assessed and measured at a minimum weekly, then monitored until it was gone. DON indicated the facility policy was for neuro checks to be completed for every unwitnessed fall or if there was a bump to the head. DON stated, "I can see there are holes in the facilities documentation and will be discussing it with the IDT [interdisciplinary team]."

During an interview on 12/28/23 at 11:53 a.m., reginal director of clinical services (RDCS) stated with all falls the facility should have falls check list to follow. The policy directs if a resident sustains a new wound from a fall, the wound should be monitored weekly at a minimum. On all residents the skin was observed daily by nursing assistants (NAs); if anything new was noted the NAs should notify the nurse. Floor nurses monitored skin weekly and documented either on the paper evaluation or in a progress note. A proper wound assessment would include looking at and documenting on redness/pinkness, swelling, edema, pain, drainage, measurements, smell, and surrounding tissue. The documentation

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F 684	Continued From page 14 should also identify if the wound was getting better or worse. RDCS explained the skin assessments/evaluations and monitoring were "not getting done right now." Facility document Fall Event Checklist dated 7/18/18, included proactive interventions placed to decrease risk of repeat falls. Monitor vital signs every shift for 72 hours this is to be put in the electronic medication administration record/electronic treatment administration record (eMAR/eTAR). Neurological checks initiated for all un-witnessed falls and /or falls in which a resident hits their head. Charge of building or DON to make sure follow-up assessment done within 24-48 hours.	F 684		

Minnesota Department of Health

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 ______	12/28/2023

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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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 12/27/23 and 12/28/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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		

Minnesota Department of Health

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 ______	12/28/2023

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2 000	Continued From page 1 The following complaints were reviewed. H51538070C (MN00099333) with a licensing order issued at 0830 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <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 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.	2 000		

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 ______	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete neurological assessments and comprehensively assess and monitor skin injuries following falls for 4 of 4 residents (R1, R2, R3, R4) who had unwitnessed falls or unwitnessed falls with injuries. Findings include: R4's face sheet included diagnoses of trochanteric bursitis, left hip, type 2 diabetes mellitus with diabetic nephropathy, age related osteoporosis without current pathological fracture,	2 830	R1 no longer resides at facility. R2 wrist wounds were assessed on 12/21/23 and had resolved. R3 had a comprehensive assessment on 1/11/24 with no abnormal findings from baseline. Bruises to legs and arms are now resolved. R4 had a comprehensive assessment on 1/11/24 with no abnormal findings from baseline. Vitals have been within baseline	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PENDING ACKNOWLEDGEMENT

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2 830	Continued From page 3	2 830		

Continued From page 3

mild neurocognitive disorder, history of falling.

R4's admission Minimum Data Set (MDS) dated 10/10/23, indicated R4 was cognitively intact, was dependent on staff for lower body dressing, was substantial to max assistance from staff for hygiene, and was partial to moderate assist from staff for toileting, mobility, and transfers. MDS also indicated R4 had a fall in the last month and another in the last 2-6 months.

R4's Safety Events report-Falls dated 10/26/23, indicated R4 had an unwitnessed fall at 7:05 p.m., that resulted in a bump on the head (no location of bump on the head was identified) and was sent to the emergency room (ER). Treatment included monitor for 72hours for bruising, change in mental status/condition, pain or other injuries related to fall. Neuro checks for every 15 minutes-times 4, then every hour- times 2, then every 2 hours- times 2, then every 4 hours- times 2, then every shift- times 3. Post fall observation every shift- times 9 to equal 72 hours.

R4's progress note dated 10/26/23, at 10:55 p.m. indicated R4 arrived back at the facility.

R4's physician visit note dated 10/27/23, indicated R4 was seen by the physician for post fall follow-up. The note did not address R4's injury to her head. Note directed staff to continue with neuro and vital sign monitoring.

R4's follow up vital signs and neuro checks sheet initiated on 10/26/23, indicated R4 was at the hospital till 8:00 p.m., on 10/26/23. R4's neuro checks did not resume until midnight on 10/27/23 then checked again on 10/27/23 at 4:00 a.m. On 10/27/23, 10/28/23, and 10/29/23, there were two other entries marked as AM and PM but no time

Provider's Plan of Correction:

and no further issues noted. Bump to forehead continues to be followed by wound nurse weekly.

All other residents who experience a fall while in the facility have the potential to be affected by this deficient practice. All residents that have experienced a fall in the facility within the past 30 days will have a post-fall assessment completed by the facility wound nurse/DON to ensure that any injuries obtained during the fall have healed appropriately or are being monitored.

The fall management and neurological check policy were reviewed with no revisions made.

Education completed with nursing staff on falls policy and procedure and neurological check process as well as education on proper skin assessments following a fall. All nurses to be educated by 1/17/24.

The DON or designee will complete audits on up to 3 residents that fall per week x 4 weeks and then up to 2 residents that fall per week x 4 weeks. Results of audits will be reported at the Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.

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 ______	12/28/2023

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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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2 830	Continued From page 4 was specified when the neuro assessments were completed. In review of R4's record it was not evident vital signs were monitored in conjunction with neuro assessments, nor a comprehensive assessment of head bump was completed, nor evident R4's head injury was continuously monitored following the incident on 10/26/23. R4's progress note dated 12/5/23 at 11:49 p.m., indicated R4 was found on the floor at 11:35 p.m. bleeding from left forehead. Resident was sent to ER. R4 returned to the facility at 4:28 a.m. with a visible wound on the left eyebrow and lump on her forehead. No further description of the head wound was included. R4's progress note from 12/6/23, at 8:03 a.m. indicated R4 was in her recliner and had a dressing on her forehead, no active bleeding. No further description was included. R4's skin assessment dated 12/6/23, included a diagram of a body. The front (face) had a circle drawn on the forehead with the words "Bump on forehead" written next to the circle. On the back of the diagram there was a circle on the middle of the back of the head with words "Bumps on head" written next to the circle. No other description of wound was included. Subsequent skin assessments were completed on 12/14/23 and12/19/23, however, did not address R4's head wound. In review of R4's record it was not evident the injury to R4's head was comprehensively assessed and continuously monitored falling the fall on 12/5/23. R4's progress note dated 12/20/23 at 8:33 a.m.	2 830		

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	00419	A. BUILDING: ___ B. WING ___	12/28/2023

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

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2 830	Continued From page 5	2 830		

indicated R4 had an unwitnessed fall and was found on the floor "hitting left forehead, L [left] forehead has a big bump with actively bleeding." R4 stated "my head is very sore and pian" The note indicated R4 was sent to the ER for further evaluation. No further description of the injury was included. Subsequent progress note at 2:18 p.m. included, "she [R4] continues to have bruising on her face and bandage on her forward [sic]" The progress note had no further description of the bruising or injury the bandage covered.

Skin assessment dated 12/21/23 and 12/27/23, did not identify the injury to R4's head. In review of R4's record it was not evident the injury to R4's head was comprehensively assessed and continuously monitored falling the fall on 12/20/23.

During an observation on 12/28/23 at 10:51 a.m., R4 sitting in her wheelchair participating in an activity. R4 had a large bandage on her forehead.

R2's face sheet included diagnoses of Parkinson's disease without dyskinesia, Alzheimer's disease, history of falling, and abnormalities of gait and mobility.

R2's quarterly MDS dated 10/30/23, indicated R2 had moderate cognitive impairment. R2 required partial to moderate assistance with dressing, bathing, toilet hygiene, and transfers. MDS identified no fall since re-admission on 7/24/23.

R2's Event report dated 11/5/23 at 1:50 p.m., indicated R2 was lowered to the floor while toileting by NA. R2 sustained a skin tear to each wrist. On the left wrist skin tear measured 5.5 centimeter (cm) by 3.0 cm and on right wrist skin

Minnesota Department of Health

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2 830	Continued From page 6 tear measured 2.0 cm by 2.0 cm. Area cleaned and covered with non-stick gauze. New treatment initiated to cleanse wound with soap and apply clean dressing change as needed. Xeroform gauze to be applied over the entire lacerated area then covered with 4 by 4 gauze and secured in place with roller gauze. In review of R2's record between 11/5/23 and 12/28/23, it was not evident the wrist wounds were assessed weekly and continuously monitored. R2's record included the following; R2's weekly skin checks completed on 11/9/23, 11/17/23, 11/20/23 did not address R2's injuries to her wrists. R2's event report dated 11/22/23 at 6:31 p.m., indicated left arm wound sustained from fall is not healed and sanguineous drainage noted in the old dressing. No further description of the wound was included. R2's skin audit dated 11/24/23, included no new skin changes and did not address injuries to R2's wrist. R2's skin audit dated 12/4/23, identified R2 had sore on left wrist, redness on her right shoulder and small bruises on both arms. The note did not include any further descriptions of impaired skin integrity. R2's progress note dated 12/8/23, indicated weekly skin assessment completed with no new injuries. The note did not identify the injuries to R2's wrist. R2's skin audit dated 12/14/23, indicated R4 refused to take shower skin check not completed.	2 830		

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2 830	Continued From page 7 R2's skin audit dated 12/15/23 and 12/25/23, did not address R2's wrist injuries. During on observation on 12/27/23, at 3:51 p.m. R2's left wrist had a thin reddish/pink line with no open areas and had minimal bruising to both arms in various stages of healing. During an interview on 12/28/23, at 10:02 a.m., case manager (CM)-A reviewed R2's record and stated R2's wrist skin tears should have been documented on in the providers notes and in the progress notes. If it wasn't in the progress notes, it wasn't done. R3's face sheet included diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), diabetes mellitus with diabetic chronic kidney disease, history of falling, unsteadiness on feet, and difficulty in walking. R3's quarterly MDS dated 11/22/23, indicated R3 had severe cognitive impairment. R3 was dependent on staff for bathing and bathing transfers, R3 did not walk, R3 required substantial to maximal assistance for transfers and dressing. R3's Safety Events Falls dated 10/27/23, identified R3 had an unwitnessed fall at 4:31 p.m. and was unable to explain why she fell. The report did not identify if R3 sustained injuries as a result of the fall. In review of R3's record it was not evident neurological assessments were completed and not evident skin assessment was completed immediately following the fall. R3's skin audit dated 11/1/23, identified R3 had bruises to his legs and arms, however, did not include any	2 830		

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2 830	Continued From page 8	2 830		

Continued From page 8

further description and did not identify causation of the bruises.

R3's Safety Events Falls dated 11/25/23, identified R3 had an unwitnessed fall at 9:30 a.m. She was found sitting on the floor between bed and wheelchair.

In review of R3's record it was not evident neurological assessments were completed after the unwitnessed fall and not evident a skin assessment was completed immediately following the fall.

R3's Safety Events Falls dated 12/19/23 at 6:52 a.m., identified R3 had an unwitnessed fall, she was found outside her room in a seated position. R3 reported she had lost her balance, fell, and did not hit her head. A skin check was done, and no injury was noted. Neuro checks started.

R3's follow-up vital signs and neuro checks document included neuro checks on 12/19/23. The first recorded neurological check was recorded at 10:00 a.m. and had multiple missing entries when neurological assessments were supposed to be completed. The last entry was recorded on 12/22/23 at 1:00 p.m.

R3's skin assessments were reviewed between 11/8/23 and 12/27/23. Skin assessment dated 12/27/23, indicated R3 had old skin bruises and a scab on left leg. However, the skin evaluations dated 11/8/23, 11/15/23, 11/21/23, 11/22/23, 11/29/23, and 12/13/23 did not identify R3 had any bruising and/or a scab on left leg. Additionally, the record did not identify when or how R3 sustained bruises that were described as "old" on the 12/27/23 assessment.

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2 830	Continued From page 9	2 830		

Continued From page 9

R1's face sheet included diagnoses of fracture of neck of left femur, chronic systolic heart failure, vascular dementia, muscle weakness, difficulty walking, long term use of anticoagulants, and cognitive communication deficit.

R1's progress note dated 12/15/23 at 6:33 p.m., indicated R1 had an unwitnessed fall and was found on the floor laying on his right side around 12:30 p.m. R1 stated she fell forward out of his recliner. R1 was sent to ER related to being on anticoagulant and returned at 6:45 p.m.

R1's progress note dated 12/16/23, at 5:23 a.m., indicated R1 had an unwitnessed fall at 5:00 a.m. R1 was found sitting on the floor beside his bed. R1 denied hitting his head and had pain in right leg.

R1's progress note dated 12/16/23, 6:38 a.m., indicated R1 wanted to go to the hospital and was transferred to the hospital at 6:34 a.m.

In review of R1's record it was not evident neurological assessments were initiated and completed after R1's falls on 12/15/23 and 12/16/23.

During an interview on 12/27/23 at 11:02 a.m., registered nurse (RN)-B stated after resident falls the floor nurse assigned to the resident gathered all the information. The nurse then provided the information to the clinical managers. RN-B indicated nurses were supposed to complete and document skin inspections after each fall. Floor nurses completed weekly skin audits and would only report new or worsening skin problems to the clinical managers. RN-B stated she has never measured or documented wound assessments and when she did wound dressing changes she

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2 830	Continued From page 10	2 830		

would not document wound descriptions or measurements.

During an interview on 12/28/23, at 11:04 a.m. RN-C stated if a fall was unwitnessed, the floor nurse should initiate neuro checks and assess for injury. Facility fall protocol directed staff take vital signs every shift for 72- hours. If a wound was found RN-C would inform the wound nurse or providers. Measuring of all wounds should be done during wound rounds by the team or wound nurse. RN-C had only completed comprehensive wound assessments and measurements on new wounds and did not complete weekly assessments and measurements for existing wounds.

During an interview on 12/27/23 at 9:48 a.m., clinical manager (CM)-B stated neuro checks were supposed to be completed after any unwitnessed fall or a fall with head injury. CM-B indicated there was a fall check list that needed to be initiated after a fall and turned into the clinical managers once completed.

During an interview on 12/28/23, at 10:02 a.m., CM-A explained when a wound was found, the floor nurse would document the wound on the wound sheet and in a progress note. Existing skin tears were supposed to be monitored and documented on weekly on the wound assessments and in a progress note. The documentation should also include if the wound was new, worsened, or if resolved. If the wound was diabetic, venous, arterial, pressure, or surgical the wound nurse and provider would follow them until resolution, but they did not follow other types of impaired skin integrity.

During an interview on 12/28/23 at 11:40 a.m.,

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2 830	Continued From page 11 director of nursing (DON) stated, expectations for new wounds following a fall would be to monitor the wound after and chart on it every shift for 3 days. The case managers were responsible for ensuring this was completed by the floor nurses. Any wound even if a bruise should be assessed and measured at a minimum weekly, then monitored until it was gone. DON indicated the facility policy was for neuro checks to be completed for every unwitnessed fall or if there was a bump to the head. DON stated, "I can see there are holes in the facilities documentation and will be discussing it with the IDT [interdisciplinary team]." During an interview on 12/28/23 at 11:53 a.m., reginal director of clinical services (RDCS) stated with all falls the facility should have falls check list to follow. The policy directs if a resident sustains a new wound from a fall, the wound should be monitored weekly at a minimum. On all residents the skin was observed daily by nursing assistants (NAs); if anything new was noted the NAs should notify the nurse. Floor nurses monitored skin weekly and documented either on the paper evaluation or in a progress note. A proper wound assessment would include looking at and documenting on redness/pinkness, swelling, edema, pain, drainage, measurements, smell, and surrounding tissue. The documentation should also identify if the wound was getting better or worse. RDCS explained the skin assessments/evaluations and monitoring were "not getting done right now." Facility document Fall Event Checklist dated 7/18/18, included proactive interventions placed to decrease risk of repeat falls. Monitor vital signs every shift for 72 hours this is to be put in the electronic medication administration	2 830		

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2 830	Continued From page 12 record/electronic treatment administration record (eMAR/eTAR). Neurological checks initiated for all un-witnessed falls and /or falls in which a resident hits their head. Charge of building or DON to make sure follow-up assessment done within 24-48 hours. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls and skin to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		