Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2023

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

RE: CCN: 245153
Cycle Start Date: May 25, 2023

Dear Administrator:

On May 25, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 August 25, 2023 (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 November 25, 2023 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	C 05/25/2023

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
E 000	Initial Comments On 5/22/23 through 5/25/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk	E 006		6/30/23

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

Electronically Signed — 06/30/2023

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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E 006	Continued From page 1 assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	E 006		

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E 006	Continued From page 2 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness plan that was based on an all-hazards approach specific to the geographic location of the facility and encompassing potential hazards. This deficient practice had the potential to affect all 57 residents at the facility. Findings include: During interview and review of the emergency preparedness plan on 5/24/23 at 11:06 a.m., the administrator confirmed he had not completed an all-hazards approach risk assessment specific to this facility.	E 006	Findings include: On 05/24/2023 at 1106 AM, it was revealed the facility had not completed an all-hazards approach risk assessment specific to this facility. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. All-hazards facility assessment was completed on 5/26/23. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Administrator will review and update as necessary the all-hazards assessment annually. In addition, the assessment will be updated as needed based off significant safety risk changes in our community. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Emergency Preparedness binders and information will be reviewed at monthly safety meetings and at QAPI. 4. Identify who is responsible for the corrective actions and monitoring compliance a. Skilled Nursing Administrator and/or designee. 5. The actual or proposed date for completion of the remedy	

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E 006	Continued From page 3	E 006	a. 05/26/23	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 013		6/30/23

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E 013	Continued From page 4 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review policies and procedures for hazards deemed significant based on an all hazards risk assessment as part of their emergency preparedness plan on an annual basis in accordance with the requirements of CFR 483.73(a)(1)(2). This deficient practice had the potential to affect all 57 residents of the facility. Findings include:	E 013	Findings include: On 05/24/2023 at 1106 AM, it was revealed the facility failed to review and update the policies and procedures on an annual basis. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. Policies and procedures were reviewed by Administrator on 6/21-6/23/23. No updates needed. 2. Address the measures that will be put	

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E 013	Continued From page 5 During an interview on 5/24/23, at 11:06 a.m. the administrator confirmed the facility failed to review and update the policies and procedure on an annual basis. The administrator verified the last review was completed in 2020.	E 013	in place to ensure the deficiency does not reoccur a. The facility safety committee has created a schedule for routine review of our emergency policies and procedures. Sections 1-3 will be reviewed 1st quarter, sections 4 and 5 reviewed in the 2nd quarter, sections 6 and 7 in the 3rd quarter and sections 8 and 9 will be reviewed in the 4th quarter of the calendar year. To be updated as needed. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. The safety committee will bring forth a quarterly report to the QAPI meeting with any concerns and modifications to any policy reviewed. Additionally, the Environmental Services Director will review the monthly log report from TELs to ensure completion. 4. Identify who is responsible for the corrective actions and monitoring compliance a. Skilled Nursing Administrator and/or designee 5. The actual or proposed date for completion of the remedy a. 06/23/23	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	E 039		6/30/23

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E 039	Continued From page 6 *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 7 exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct	E 039		

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E 039	Continued From page 8 exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 9 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039		

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	245153	A. BUILDING _____ B. WING _____	C 05/25/2023

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E 039	Continued From page 10 accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039		

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E 039	Continued From page 11 accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from	E 039		

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E 039	Continued From page 12 engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 13 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain	E 039		

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E 039	Continued From page 14 documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure exercises had been conducted to test their emergency plan at least annually, including unannounced staff drills using the emergency procedures. This deficient practice had the potential to affect all 57 residents residing at the facility. Findings include: On 5/24/23 at 11:06 a.m., the administrator stated they had completed fire drills, however confirmed the facility had not completed or planned full-scale exercises or table-top exercises to test their emergency plan.	E 039	Findings include: On 05/24/2023 at 1106 AM, it was revealed the facility had not completed or planned full-scale exercises or table-top exercises to test their emergency plan. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. A table top exercise was completed 6/5/23 which was based on our norovirus outbreak in May 2023. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. The facility safety committee will plan, schedule and execute the required emergency preparedness drills. The safety committee agenda has been	

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E 039	Continued From page 15	E 039	updated to include this topic to include annual scheduling. A live exercise to be planned at next safety meeting in July with local police and/or fire department. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. The safety committee chair will bring forth to the quarterly QAPI meeting pertinent reporting on annual emergency preparedness drills. This report will include: most recent date of drills as well as the outcome/results of the drills. 4. Identify who is responsible for the corrective actions and monitoring compliance a. SNF Administrator and/or designee 5. The actual or proposed date for completion of the remedy a. 06/05/23	
F 000	INITIAL COMMENTS On 5/22/23 through 5/25/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51532212C (MN00089510), H51532213C (MN00083850), H51532214C (MN00089230), H51532221C (MN00092029), H51532243C (MN00087000), H51539861C (MN00092314), H51532343C (MN00093639).	F 000		

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F 000	Continued From page 16 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 substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		7/14/23

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F 583	Continued From page 17 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 1 resident (R2) while using the bathroom and during personal cares. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 4/18/23, identified R2 had intact cognition and required moderate assistance with most activities of daily living (ADLs). Diagnoses included depression, muscle weakness, hypertension (high blood pressure), thyroid disorder, and lymphedema (localized swelling of the body). R2's care plan dated 1/27/22, indicated staff would always leave her room door open and bathroom door ajar however lacked interventions for staff to use to ensure personal privacy. During an observation on 5/22/23, at 6:39 p.m., R2 was in her bathroom, with the door opened, disrobed while seated on the toilet. R2 was visible to other residents and visitors from the hallway.	F 583	"Care plan for R2 updated on 6/26/23 to reflect current interventions to ensure resident s personal privacy. "On 6/26/23, EVS measured and purchased a life safety approved curtain for R2 s room to aide in privacy per her preference. "All facility residents will be interviewed by clinical managers regarding their privacy preferences during cares and toileting. Care plans will be updated as needed. All interviews will be completed by 7/7/23 with care plans updated. "Nursing staff received education regarding resident privacy and dignity. "Resident privacy audits will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 583	Continued From page 18 At 6:45 p.m., nursing assistant (NA)-E asked R2 if she needed more time or if R2 was done using the bathroom. R2 stated she needed more time and would place on her call light when she was ready. NA-E left R2's bathroom and the doors remained open. During an interview on 5/22/23, at 6:50 p.m., NA-E confirmed R2 was in her bathroom undressed, seated on the toilet and was visible to other residents, family and visitors from the hallway. NA-E stated R2 requested the doors be left open. NA-E confirmed R2 was visible to all staff, residents, and family from the hallway when she was in the bathroom with the doors left open. During an interview on 5/23/23, at 2:55 p.m., trained medication aide (TMA)-D stated staff did not close R2's doors because she would become angry with staff when they closed the doors. TMA-D confirmed that R2's doors remained open during personal cares and toileting. TMA-D stated she attempted to stand in front of R2 to block others from seeing her however sometimes R2 requested to be left alone in the bathroom for a few minutes. During those times, she was exposed and visible to others who walked past her room. During an interview on 5/24/23, at 8:30 a.m., registered nurse (RN)-A stated all residents should be provided privacy during cares. RN-A indicated R2 did not want her doors closed so they were left open when R2 used the bathroom and during personal cares. RN-A was not aware of any interventions the facility could implement that would allow R2's doors to remain open while still being provided privacy.	F 583		

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F 583	Continued From page 19 During an interview on 5/24/23, at 9:10 a.m., NA-F stated R2 refused to have her doors closed during personal cares and while she used the bathroom. NA-F stated anyone in the hallway could see R2 seated on the toilet or see staff assisting her with personal cares. NA-F stated he attempted to position himself in front of R2 to prevent others from seeing her exposed. NA-F indicated R2 usually requested a few minutes alone when using the bathroom and stated again anyone who walked past her room could see her exposed. NA-F stated he would like to be informed of other ways he could provide privacy while respecting R2's wishes to have her doors remain open. During an interview on 5/24/23, at 10:07 a.m., R2 stated she wanted her bathroom and room doors left open because she is claustrophobic. R2 stated she was aware when she was receiving cares in her bathroom she could be exposed to anyone who walked past her room. R2 indicated she would prefer to have privacy while in her bathroom however closing the doors caused her anxiety. R2 stated the facility had not attempted any alternative options that would allow her personal privacy in her bathroom while continuing to leave the doors open. During an interview on 5/24/23, at 10:56 a.m., licensed social worker (LSW)-A stated R2 refused to have her doors closed and would "scream at staff" if they attempted to shut them. LSW-A confirmed when R2 was in her bathroom she was visible to other residents and visitors from the hallway. During an interview on 5/25/23, at 9:41 a.m., NA-G stated she assisted R2 with her baths twice	F 583		

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F 583	Continued From page 20 a week. NA-G indicated she would pull the curtain to provide privacy if R2 refused to have the door closed however stated R2 allowed her to close the door with each bath. During an interview on 5/25/23, at 10:30 a.m., the director of nursing (DON) stated she expected staff would provide privacy when providing personal cares to R2. DON stated privacy could be achieved in various ways by closing doors, pulling the privacy curtain, closing the window blinds, keeping resident's private areas covered and only expose what was necessary at the time. DON stated when a resident's door could not be closed, she would still expect personal privacy to be a priority and staff would offer alternative choices to provide privacy. DON stated she was unaware R2 had not been provided privacy when using the bathroom and during personal cares and indicated it was unacceptable. A facility policy titled Resident rights and notification of resident rights, dated 11/28/17, indicated the facility acted to protect and ensure the rights of the residents.	F 583		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 699		7/14/23

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F 699	Continued From page 21 Based on observation, interview and document review, the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 1 of 1 resident (R17) who had post-traumatic stress disorder (PTSD). Findings include: R17's quarterly Minimum Data Set (MDS) assessment dated 4/4/23, identified R17 had intact cognition and required assistance with most activities of daily living (ADLs). Diagnoses included: PTSD, anxiety, paraplegia, and major depressive disorder. R17's care plan dated 4/4/23, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. R17's hospital discharge summary dated 8/27/20, identified diagnosis of PTSD resulting from being a victim of abuse. During an interview on 5/22/23, at 3:37 p.m., R17 indicated she had a diagnosis of PTSD however stated she did not wish to discuss it as it was personal to her and hard to discuss with someone she was not familiar with. During an interview on 5/23/23, at 4:42 p.m., nursing assistant (NA)-B stated he was not aware R17 had PTSD. NA-B indicated he was not sure if he had received training regarding trauma informed care.	F 699	"Care plan for R17 was updated on 5/24/23 her wishes as it pertains to her diagnosis of PTSD. "On 5/24/23, all like facility residents with a history of post-traumatic stress disorder (PTSD) were reviewed. No like residents identified at this time. "Trauma Informed Care Assessments will be completed for all residents upon admission. Residents identified to have a diagnosis or history of post-traumatic stress disorder will be reviewed for triggers to avoid potential re-traumatization and individualized trauma-informed approaches. Care plans will be updated accordingly. "Facility staff received education regarding post-traumatic stress disorder, resident specific triggers, and resident-specific trauma-informed approaches. "Trauma informed care plan audits will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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	245153	A. BUILDING _____ B. WING _____	C 05/25/2023

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 699	Continued From page 22 During an interview on 5/23/23, at 4:45 p.m., registered nurse (RN)-B stated she would discover a resident had PTSD upon admission after she reviewed the hospital discharge summary. RN-B stated she was not aware of specific requirements of care planning for a resident with PTSD. RN-B indicated R17 had a diagnosis of PTSD and verified she was not aware of any specific triggers or interventions in place for R17. RN-B confirmed R17's care plan lacked evidence of trauma triggers and interventions for her diagnosis of PTSD. During an interview on 5/23/23, at 4:57 p.m., licensed social worker (LSW)-A stated she completed a trauma informed care observation for every resident upon admission. LSW-A indicated when a resident had a diagnosis of PTSD, the nursing staff would add the trauma triggers and interventions to the resident's care plan. LSW-A stated the care plan was shared with all staff through their electronic health records (EHR) behavior monitoring documentation. LSW-A confirmed R17 had a diagnosis of PTSD. During an interview on 5/23/23, at 5:05 p.m., the director of nursing (DON) and regional director (RD), DON stated each resident was assessed for trauma upon admission. If a resident had a diagnosis of PTSD, the staff were expected to find out what the trauma was associated with, identify the triggers, care plan how to avoid the triggers, and identify the specific interventions to be used if the resident's triggers were activated. Both DON and RD stated R17 had a diagnosis of PTSD and confirmed R17's care plan lacked specific triggers and interventions related to PTSD and past trauma.	F 699		

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F 699	Continued From page 23 A facility policy titled Trauma-Informed Care, dated 8/2022, identified residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. If the trauma survivor was reluctant to share history, the facility was still responsible to try to identify triggers which may cause re-traumatization and develop care plan interventions which minimize or eliminate the effect of the trigger.	F 699		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/23/2023. At the time of this survey, Madonna Towers of Rochester was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/30/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The building was constructed a Type V(111) on the following dates. 1967 - original 1 story - No basement 1979 - 1 story - No basement addition for new front wing 1998- 1 story addition with no basement 2002 - 1 story - No basement Memory care wing addition. Building is fully sprinklered with full automatic fire alarm notification to the fire department.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 62 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), sections 19.7.1.4 through 19.7.1.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/23/2023 at 10:15 AM, it was revealed that a fire drill on the 2nd shift during the 3rd quarter was not conducted. An interview with the Maintenance Director verified this deficient finding at the time of	K 712	Findings include: On 05/23/2023 at 1015 AM, it was revealed that a fire drill on the 2nd shift during the 3rd quarter was not conducted due to the system not being able to alarm while waiting for a fix of the sounding system. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. Fire panel has been fixed and working properly. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur a. Environmental Services Director	6/30/23

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K 712	Continued From page 3 discovery.	K 712	educated that he should have conducted a “silent” drill during that time frame. Between the hours of 9pm and 6am, a coded announcement may be used instead of audible alarms. b. Monthly TELs task entered to help remind EVS Director to complete. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Fire drills will be reviewed at monthly safety meetings and at QAPI. 4. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee 5. The actual or proposed date for completion of the remedy a. 05/23/23	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		6/30/23

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K 918	Continued From page 4 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.4 (A) through 6.4.4.1.4(C) and NFPA 110 (2010), Standard for Emergency and Standby Power Systems section 8.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/23/2023 at 10:30 AM, it was revealed a review of available documentation that the only monthly 30 minute test exercised under load on the emergency generator was documented on 02/15/23 and 7/25/22.	K 918	Findings include: On 05/23/2023 at 1030 AM, it was revealed a review of available documentation that the only monthly 30 minute test exercised under load on the emergency generator was documented on 2/15/23 and 7/25/22. 1. Detailed Description of the corrective action taken or planned to correct the deficiency a. A load test was completed on 5/23/23 findings were documented per regulation. Issues identified during the load test with losing power. Pioneer notified and came in on 6/12/23 to check system and fixed the problem. Load test run on this date with Pioneer and no issues noted. 2. Address the measures that will be put in place to ensure the deficiency does not	

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K 918	Continued From page 5 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	reoccur a. Environmental Services Director educated on regulations regarding the load bank testing. Education including timing, documentation, and appropriate follow up required. b.. Monthly TELs task entered to help remind Environmental Services Director to complete. c.. Load tests will be conducted per regulation going forward. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained a. Load tests will be reviewed at monthly safety meetings and at QAPI. 4. Identify who is responsible for the corrective actions and monitoring compliance a. Director of Environmental Services and/or designee is responsible for ensuring the load bank tests are completed, documented and followed up on appropriately. 5. The actual or proposed date for completion of the remedy a. 05/23/23	