STATE LICENSING COMPLIANCE REPORT

Report #: HL20211001C

Date Concluded: March 15, 2022

Name, Address, and County of Facility Investigated:

Madonna Towers
4001 19th Avenue, NW
Rochester MN 55901
Olmsted County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20211	A. BUILDING: _____ B. WING _____	C 03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW 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) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL20211001C / HL20211002C On March 1, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were #139 residents receiving services under the assisted living license. The following correction orders are issued for #HL20211001C and HL20211002C, tag identification 1620, 1760, 2160.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required nursing assessments were completed timely by a registered nurse (RN) for two of three residents (R2, R3) records reviewed. R2 and R3 had periods of nearly six months between assessments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	01620		

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01620	Continued From page 2 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: R2's resident profile indicated she was admitted to the facility on July 25, 2018. R2's service plan, dated March 7, 2022, indicated R2 received services for housekeeping, laundry, meals, dressing, grooming, bathing, and medication administration and management. R2's service plan indicated R2 had impaired judgement and decreased safety awareness. The plan indicated the RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required; Pre-Admission Assessment, 14-day assessment: completed up to 14-days after start of services, Ongoing assessment: completed periodically but no less than every 90-days and change in resident condition. On March 1, 2022, R2's last two nursing assessments were requested. Assessments completed for R2 dated September 15, 2021, and February 25, 2022 were provided. R3's resident profile indicated the most recent admission was on January 4, 2018. R3's service plan, dated January 11, 2022, indicated R3 received services for housekeeping, laundry, meals, dressing, grooming, bathing, continence care, and medication administration and management. R3's service plan indicated R3 had impaired judgement and decreased safety	01620		

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01620	Continued From page 3 awareness. The plan indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required; Pre-admission assessment, 14-day assessment: completed up to 14-days after start of services, ongoing assessment: completed periodically but no less than every 90-days and change in resident condition. On March 1, 2022, R3's last two nursing assessments were requested. Assessments completed for R3 were dated April 19, 2021, and October 19, 2021, were provided. On March 11, 2022, in an email correspondence, RN-A stated and validated that the assessment documents that were provided, were the two most recent evaluations for each R2 and R3. Policy titled Initial and On-going Assessments of residents indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required; Pre-admission assessment, 14-day assessment: completed up to 14-days after start of services, ongoing assessment: completed periodically but no less than every 90-days and change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 4 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure standard medication practices were followed when a pill was left on the table and not verified it was taken for one of one (R3) resident reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On March 1, 2022, at 6:40 p.m., during observations in the memory care unit, a medication cup with an unidentified tan colored pill was observed on the table in front of R3. There were five other residents also seated at the dining table.	01760		

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01760	Continued From page 5 On March 1, 2022, at 6:41 p.m., registered nurse (RN)-A removed the medication cup with the pill in it from the table. RN-A was overheard asking unlicensed staff person (ULP)-B if she had left the medication. ULP-B denied giving any medications to R3. RN-A also asked ULP-C if he had given the medication, and ULP-C also denied giving the medication. ULP-B and ULP-C were the only two staff working on the unit at that time. At that time, RN-A was asked if this was facility practice to leave medications in front of residents and not verifying the medications were taken and RN-A stated that it was not facility practice. On March 1, 2022, at 6:45 p.m., ULP-B stated the med was given by the colleague that was on day shift and had left for the day. R3's service plan dated January 11, 2022, indicated R3 received services for housekeeping, laundry, meals, dressing, grooming, bathing, continence care, and medication administration and management. R3's service plan indicated R3 had moderate cognitive impairment and impaired judgement. Facility Policy titled Medication, Treatment, and Therapy Administration, dated August 1, 2021, indicated medications, treatments, and therapies are administered to residents using standards of nursing practices by licensed or trained unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01760		

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02410	Continued From page 6	02410		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident choice, dignity and privacy for one of one (R1) residents reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02410		

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02410	Continued From page 7 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's service plan, dated January 11, 2022, indicated R1 was most recently admitted on May 18, 2021 and received services for housekeeping, laundry, meals, dressing, grooming, bathing, continence care, and medication administration and management. R1 had moderate cognitive impairment and impaired judgement. Review of email correspondence to facility administration dated January 10, 2022, indicated a request was made for staff to close R1's curtains at dusk to prevent direct line of exposure into R1's room and bathroom and to prevent what happened the preceding week. Video footage recorded on January 26, 2022, at 8:05 p.m., from inside R1's room was reviewed. The video showed a facility staff person (unknown) standing by and watching R1 undress and dress herself for bed. R1 stood unsteadily while attempting to change into her bedtime clothing while the staff person stood and watched on the opposite end of R1's walker. The door to R1's room was wide open with full view of R1 dressing to anyone outside the room. The blinds and curtains are also open with full view of R1 undressing from anyone outside the window and directly into the parking lot. Review of email correspondence dated January 26, 2022, indicated facility management was made aware of the incident on the evening of	02410		

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02410	Continued From page 8 January 26 and that it was the third time it had occurred since the concern was initially raised to administration. Review of email correspondence dated March 14, 2022, indicated that on March 12, 2022, at 6:30 p.m., R1 was viewed on video undressing and dressing for bed. The curtains were still wide open, and it was dark outside. R1 successfully undressed and redressed with the curtains wide open. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02410		