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	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Towers of Rochester Inc	4001 19th Avenue Northwest Rochester, MN 55901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51576 Based on observations, interview, and document review, the facility failed to provide the opportunity to make choices related to toileting for 2 of 3 residents (R1, R2) reviewed for choices. Findings include: R1's face sheet dated 2/12/25, identified diagnoses of stress fracture of left tibia (hairline crack in the shin bone) and fracture of middle phalanx of left finger. R1's admission minimum data set (MDS) dated [DATE], identified resident to be cognitively intact. R1 was dependent for all transfers and frequently incontinent of bowel. R1's care plan dated 2/12/25, identified R1 was dependent for all transfers with a total mechanical lift. During an interview on 2/11/25 at 3:50 p.m., R1 stated it had been two days since she has been able to have a bowel movement due to having to use the bedpan instead of using the toilet. R1 stated, I don't feel like I have any power over anything anymore, they tell me when to eat, when to bathe, and when to get up. R1 stated when she puts her call light on to bathroom to have a bowel movement, staff just put her on a bedpan and do not give her an option to sit on the toilet. During an interview on 12/12/25 at 2:08 p.m., R1's family member (FM)-A stated it is a point of dignity she should not have to ask to go to the bathroom laying in bed if it does not work for her. R2's face sheet dated 2/12/24, identified diagnosis of multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves) and neurogenic bladder (condition where a person has lack of bladder control). R2's quarterly MDS dated [DATE], identified R2 was cognitively intact and occasionally incontinent of bowel and bladder. R2's care plan dated 12/12/24, identified R2 was assist of two for toileting with a total mechanical lift. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/25 at 1:48 p.m., R2 stated staff were using a ceiling lift in her room previously to allow her to sit on the toilet to have a bowel movement, but since the ceiling lift has been out of use the only way she can have a bowel movement was to sit on a bedpan or go in her incontinent garment. R2 explained when she asked to use the toilet to have a bowel movement, staff told her she had to use the bedpan instead of the toilet. Using the bedpan made made R2 feel not good . During an interview on 12/12/25 at 8:47 a.m., regional director registered nurse (RDRN)-B stated if a resident requests to use the toilet it should be care planned to do so and staff should be honoring their request. During an interview on 12/12/25 at 2:50 p.m., director of nursing (DON) stated if a resident's preference to use the toilet to have a bowel movement this should reflect on their care plan, along with their request to not use the bedpan. The staff should be treating the resident in a dignified manner and staff should follow the resident wishes. Review of the facility's Activities of Daily Living policy dated 6/21, identified interventions to improve and or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51576 Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed to implement care and services for catheter care and bowel continence for 1 of 1 resident (R1) reviewed for bowel and bladder incontinence/catheter. Findings include: R1's face sheet dated 2/12/25, identified diagnoses of diabetes mellitus, stress fracture of left tibia, chronic kidney disease. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact and had an indwelling urinary catheter and frequent bowel incontinence. R1's care area assessment (CAA) dated 12/19/24, identified R1 needed assistance for toileting due to indwelling catheter. R1's physician progress note dated 12/18/24, identified R1 had an indwelling urinary catheter placed during a hospitalization for urinary retention. R1's nursing assistant care guide updated 2/5/25, directed staff that R1 had a catheter. However, did not give any direction to staff to provide catheter care or toileting plan. R1's care plan infection focus dated 12/13/24, identified R1 required enhanced barrier precautions (EBP) due to presence of indwelling catheter. Intervention for staff to apply gloves and gowns prior to high-contact activities. R1's care plan did not identify interventions to manage or care for the indwelling catheter or a toileting plan for bowel continence. During an interview on 2/12/25 at 2:08 p.m., family member (FM)-A stated R1 would have a bowel movement every day like clockwork at home. During an interview on 2/12/25 at 2:13 p.m., R1 stated she was able to hold her bowel when she was at home and did not have any episodes of incontinence. R1 stated the facility did not discuss the risks of having a catheter or inquire about my bowel pattern at home. During an interview on 2/12/25 at 2:33 p.m., nursing assistant (NA)-J stated R1's nursing assistant care sheet did reflect she has a catheter, however, did not reflect how to care for it or have a toileting schedule on it. During an interview on 2/12/25 at 2:50 p.m., director of nursing (DON) stated R1's comprehensive care plan did not address interventions for catheter care or toileting plan for bowel continence. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Comprehensive Assessment and Care Planning policy dated 9/27/23, identified the facility must assess continence to develop, review and revise the resident's person-centered comprehensive care plan and all person-centered care plan interventions will be implemented by qualified personnel, and may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. Residents and resident representatives will be involved in the comprehensive person-centered care planning.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and record review the facility failed to comprehensively reassess and demonstrate adequate justification for the continued use of indwelling catheter for 1 of 1 resident (R1) reviewed for falls. In addition the facility failed to ensure a resident who was continent of bowel received services to maintain bowel continence for 1 of 1 resident (R1) reviewed for resident safety. Findings include: Catheter justification: R1's care plan dated 12/13/24, identified R1 required Enhanced Barrier Precautions (EBP) related to presence of indwelling catheter device .R1's care plan was reviewed and identified no indication for a foley catheter with no interventions to monitor for signs and symptoms of infection. R1's Care Area Assessment (CAA) dated 12/14/24, section 6 urinary incontinence identified CAA triggered due to use of an indwelling catheter and need for assistance with toileting. R1 has a catheter in for skin care management, due to history of incontinence and reduced mobility with current fracture. The CAA did not address plan for urinary indwelling catheter removal. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact and had the use of indwelling catheter. R1's Physical Therapy (PT) progress note dated 12/21/24, identified R1 complained of catheter pain. R1's PT progress note dated 1/22/24, identified R1 complained of catheter pain. R1's Occupational Therapy (OT) progress note dated 12/22/24, identified R1 complained of burning in her catheter site. R1's OT progress note dated 12/27/24, identified R1 complained of pain in her catheter. R1's MD progress note dated 12/27/24, identified during R1's hospitalization from [DATE] to 12/23/24, R1 developed urinary retention and hence Foley catheter was placed .R1 was recommended to follow-up with urology to undergo voiding trial (a procedure used to assess a patient's ability to urinate without the assistance of a urinary catheter). R1 has an upcoming appointment on 1/24/2024 with urology. R1's MD Progress note dated 1/24/25, identified .R1 had developed urinary retention while hospitalized in December 2024 and has had an indwelling urinary catheter since. She will be seeing urology today and anticipates a voiding trial will be done . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Urology Appointment dated 1/24/25, identified R1 experienced urinary retention in the hospital with over a liter in her bladder with moderate hydronephrosis (a condition where urine builds up in the kidney, causing it to swell). This was in the setting orthopedic injury and surgery with narcotics. R1 has an indwelling Foley catheter that has been in place for the last month. This was really helpful to her because she still is not mobile. New orders identified that a catheter change will be completed, will keep catheter in and do monthly catheter changes until R1 is mobile enough so she would be able to go to the bathroom if the catheter was removed, at that time a voiding trial will be done. R1's progress note dated 2/4/25 at 10:28 p.m., identified a nursing assistant reported that R1 was uneasy and complained of discomfort. R1 stated that she feels the urge to pee. Abdomen noted to be tender and has low urine output in the catheter bag, 100 cc. On-call provider notified and obtained verbal order to flush the urinary catheter with 60 mL of sterile normal saline. Urinary catheter was flushed as per order. Catheter was draining with urine output of 1000 milliliters (ML) in the catheter bag. During an observation and interview on 2/11/25 at 4:05 p.m., R1 was seated in her wheelchair in her room and was noted to have a catheter bag. R1 stated she has had the catheter for convenience because since she fractured her leg she can't get to the bathroom easily. At 4:38 p.m., nursing assistant (NA)-J and NA-K assisted R1 to the toilet. NA-J stated she needed to change R1's brief because it was wet from R1's leaking urine from her catheter. During a phone interview on 2/12/25 at 2:08 p.m., family member (FM)-A stated she brought R1 to the urology appointment on 1/24/25, where they changed R1's catheter. FM-A further stated R1 has her catheter for convenience every time she would have to urinate, she would need a full body mechanical lift to go to the commode. The facility has a hard time getting her to the toilet now. FM-A stated prior to R1's hospitalization R1 was completely continent of bladder. FM-A stated last week the facility called her about a blockage in R1's catheter they had to call the doctor to take care of it. During an interview on 2/12/25at 2:13 p.m., R1 stated she did not remember anyone in the facility talking to her about the risks of having the catheter. R1 further stated, they never talked to her about it and did not have a doctor here tell me about the risks. During an interview on 2/12/25 at 2:50 p.m., director of nursing (DON) indicated she was aware that R1 did not have a clinical diagnosis for her catheter use. DON stated she was not aware that R1 had an appointment with urology on 1/24/25, that indicated R1 had new orders to have her catheter changed once a month. DON would follow up with urology to ensure if the facility would be doing the catheter change or if R1 would have to go to an outside appointment for it. DON was unable to find documentation of education of risks and benefits of catheter use were given to R1. During an interview on 2/12/25 at 3:37 p.m., medical director (MD)-A stated R1 currently has a catheter for convenience and does not have a diagnosis for justification of use. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, Prevention of Catheter-Associated Urinary Tract Infections (CAUTI), revised 8/30/23, identified Purpose: Though prevalence of indwelling urinary catheter use in the long-term care setting is lower than in the acute care setting, catheter-associated UTI (CAUTI) can lead to such complications as cystitis, pyelonephritis, bacteremia, and septic shock. These complications associated with CAUTI can result in a decline in resident function and mobility, acute care hospitalization s, and increased mortality. Prevention is key. Policy: It is the policy of Benedictine communities that indwelling urinary catheters are eliminated whenever possible. A resident who admits to the community without an indwelling catheter is not catheterized unless the resident's clinical condition indicates categorization is necessary for their well-being. General Considerations: 1. When a resident is admitted to the facility with a catheter in place, a thorough physical assessment, as well as history review will be completed. 2. Once reviewed, primary physician will be notified for catheter removal, if there is not a medical reason for use of catheter. 3. Intermittent catheterization will be used whenever possible rather than indwelling catheter. 4. An indwelling catheter is used only after alternative methods have failed . Bowel Continence: R1's Bowel Observation dated 12/18/24, identified R1 was always continent of bowel and to monitor R1 for constipation due to opiate use. Section 6 treatment/management for program placement was not assessed. Section 7 Bowel summary was left blank. R1's care plan dated 12/18/24 identified a problem with ADL's functional status. R1 had a self-deficit with bowel and bladder. Interventions dated 2/4/25, identified do not use the belted mesh hygiene (toileting) sling. R1's care plan was reviewed and did not identify person centered interventions to resident preference with toileting such as bed pan, commode or toilet, and did not identify toileting plan interventions to maintain bowel continence. R1's Care Area Assessment (CAA) dated 12/19/24, section 5: Activities of Daily Living (ADL's) identified R1's CAA triggered due to left tibial fracture, with non-surgical treatment, was in a long cast and non-weight bearing for at least 6 weeks and being followed by orthopedics and medical doctor. Care plan will be developed due to mobility and cares. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1's cognition was intact and R1 was frequently incontinent of bowel. Further identified R1 was dependent with toileting transfers and required substantial to maximal assist with toileting hygiene. R1's care sheet dated 2/3/25, identified R1's toileting to transfer to/from bed, to pull down pants before/after toileting for clothing management. R1 required assist of 1 with adl's and transferred with ez-way mechanical lift x 2. R1's care sheet lacked information how to transfer R1 to the toilet what type of sling to use and also lacked toileting plan to maintain bowel continence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/11/25 at 4:05 p.m., R1 was seated in her wheelchair in her room and was noted to have her call light on. R1 stated she had her call light on to try and get on the toilet because she had not had a bowel movement for two days since the staff have been making her use the bed pan. R1 further stated, I used to go every day like clockwork between 1 and 3 pm and it would take me less than 5 minutes. R1 stated now that she hadn't had a bowel movement in two days. R1 had felt gassy earlier and felt full. R1 stated she was going to ask for a laxative if nothing happens. At 4:08 p.m., nursing assistant (NA)-J came in the room, R1 asked NA-J if she could get on the toilet, NA-J stated she was unable to find another staff to help with that. R1 asked NA-J if she would be here tomorrow to try and help her with that? NA-J stated to R1, ok I will see you tomorrow and left the room. R1 stated she did not get the option to use the toilet only the bed pan. R1 stated, I just can't have a bowel movement laying down on a bed pan, I have to be sitting up to go. At 4:14 p.m., RN-D walked in the room and offered R1 some Miralax, R1 asked when she would be able to be able to get to the toilet if she took the Miralax. R1 then asked when it would be a good time for her to go to the bathroom. Registered nurse (RN)-D did not answer R1 and R1 declined the Miralax and RN-D left the room. During a continuous observation on 2/11/25 from 4:18 p.m. to 4:40 p.m., NA-J and NA-K positioned a sling under R1 in the wheelchair and were attempting to transfer R1 to the toilet with the ez-way lift (mechanical lift). NA-J and NA-K struggled to get R1's pants down, but were able to get her pants down and pull R1's brief to the side, R1 then was lowered onto the toilet that had a toilet riser on it. When R1 was seated on the toilet her legs were dangling about a foot above the ground. R1 stated she had a bowel movement and was done. NA-J and NA-K transferred R1 with the use of the ez-way lift from the toilet in her bathroom to her bed and performed toileting hygiene. R1 stated you can't imagine how much better I feel. NA-J stated R1 had a medium formed bowel movement and stated they had not been offering R1 the toilet only the bed pan because it took a lot of time to transfer R1 to the toilet with the ez-way lift. During an interview on 2/12/25 at 8:47 a.m., regional director registered nurse (RDRN)-B stated if a resident requested to use the toilet versus the bed pan it should be care planned to do so and the staff should be honoring her request. During a phone interview on 2/12/25 at 2:08 p.m., family member (FM)-A stated prior to R1's stay here she was completely continent of bowel. FM-A stated the staff have not been offering R1 the toilet instead had been offering a bed pan. FM-A stated R1 had shared the struggles of not being able to have a bowel movement with a bed pan. During an interview on 2/12/25 at 2:13 p.m., R1 stated she was able to hold her bowel when she was at home and did not have any episodes of incontinence. During an interview on 2/12/25 at 2:50 p.m., director of nursing (DON) stated R1's bowel assessment did not identify patterns of incontinence to determine a toileting schedule and stated the care plan did not identify a preference for how R1 preferred to use the bathroom. Facility bowel assessment policy was requested and not received. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, Activities of Daily Living (ADL), dated June 2021, identified the Purpose: To provide residents with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Policy: Residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. Implementation: 1. Care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care), b. Mobility (transfer and ambulation, including walking) c. Elimination (toileting) .4. Interventions to improve and/or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 5. The resident's response to interventions will be documented, monitored, evaluated and revised as appropriate. 51576