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	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Towers of Rochester	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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safety during van transport by ensuring safety straps were appropriately applied for 1 of 1 resident (R1). The failure resulted in actual harm when the van came to a sudden stop throwing R1 from the wheelchair causing fractures to her right and left femurs. The facility had completed corrective measures by 5/26/26 and prior to the start of the survey so citation was issued at past non-compliance (PNC). Findings include: R1's face sheet dated 6/4/26, identified diagnoses of unspecified fracture of shaft of right femur (long bone), unspecified fracture of shaft of left femur, displaced supracondylar fracture without intercondylar extension of lower end of left femur (break just above the knee joint), Alzheimer disease, anemia, unilateral primary osteoarthritis of left knee, muscle wasting and atrophy, and muscle weakness. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment, had clear speech, sometimes understands, and no behaviors. R1 had no impairment to upper or lower extremities, required substantial assistance with dressing, rolling, sitting; staff propelled wheelchair. R1's care plan dated 4/4/25, identified R1 transferred with one assist and mechanical standing lift. R1 did not ambulate. During an interview on 6/4/26 at 10:14 a.m., nursing assistant (NA)-A stated prior to 5/22/26, R1 used a standing mechanical lift with one person assist. R1 had a really big fancy wheelchair that was easy to tilt back and forward. R1 did not slide in the wheelchair once positioned. R1's Nursing Home Incident Report NHIR) dated 5/22/26, identified around 1:00 p.m. on 5/22/26, R1 slid out of her wheelchair while being transported back to the facility. R1 was assessed by nursing staff and around 3:00 p.m. was transferred to the emergency department due to increased pain. R1's Emergency Department provider notes dated 5/22/26, identified R1 had went to an appointment accompanied by family member (FM)-A via wheelchair van. Upon return from the appointment, FM-A stated R1 was improperly fastened in her wheelchair during transport. When the vehicle came to an abrupt stop from approximately 15 miles per hour at a stoplight, R1's wheelchair moved one to two feet forward causing her to slide out the wheelchair onto the floor of the vehicle landing with right lower extremity flexed with right foot positioned beneath buttocks. R1 was lifted by bilateral axillae (armpits) and placed back in wheelchair before returning to facility. On physical exam R1 had left lower extremity pain with no obvious deformity or other areas of tenderness. R1 was diagnosed with fracture femur shaft closed initial right and fracture femur shaft closed initial left. Facility email from van driver (VD)-A to campus wellness director (CW)-A dated 5/23/26 at 2:32 p.m., identified VD-A had resigned due to the driver position being too challenging for him. Facility investigation included a signed letter dated 5/25/26 from FM-A. The letter identified on 5/22/26 around 12:30 p.m., VD-A transported FM-A and R1 from a medical appointment. FM-A identified VD-A appeared to be struggling with securing the wheelchair tie downs. FM-A's letter identified VD-A asked FM-A if it was okay to not attach the upper shoulder strap/seat belt piece and FM-A agreed as the trip to facility was less than a mile. When VD-A braked at a stoplight, R1's wheelchair lurched forward six inches to one foot. The front tie downs were still secured but FM-A thought the back ones were not secured and were loose. FM-A watched R1 slide out of the wheelchair (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	onto the floor with her right leg tucked under her body at a 90-degree angle. VD-A and FM-A placed R1 back in the wheelchair by FM-A holding R1's arms and VD-A assisted with lower half of body. R1's Safe Lifting and Movement observation dated 6/1/26, identified R1 was a two-person transfer with full lift as R1 was unable to bear weight. During an interview on 6/4/26 at 1:42 p.m., licensed practical nurse (LPN)-A who was also the case manager stated on 5/22/26, VD-A had not called her or informed her of the situation that occurred with R1. Around 1:15 p.m., LPN-A was made aware of the situation and went to R1's room to assess her while seated in her wheelchair. R1 complained of knee pain, which LPN-A stated was R1's baseline pain. However when staff attempted to transfer R1 using the standing mechanical lift, R1 complained of pain so staff used the full body mechanical lift to move R1 to her bed. FM-A and LPN-A decided to send R1 to the emergency department. During an observation and interview on 6/4/26 at 10:22 a.m., R1 was lying in her bed. R1 stated on 5/22/26, the incident happened fast and she did not think she was buckled in. R1 indicated since the incident she was somewhat afraid to ride in the bus if she had to go out for an appointment. During an observation and interview on 6/4/26 at 10:30 a.m., CW-A stated van driver (VD)-A had been employed at facility since 5/15/26. VD-A was onboarded on 5/15/26, had computer training on 5/19/26 and 5/20/26. VD-A shadowed with other VD's and was cleared to drive on his own. CW-A interviewed VD-A after the incident on 5/22/26, and VD-A stated he did not utilize the seat belt properly when transporting R1. CW-A went outside the facility to the mobility van with an empty wheelchair. CW-A opened the back of the van for the wheelchair to lift to come down. CW-A placed the wheelchair on the lift and then brought the wheelchair into the van. The wheelchair was facing the front of the van. The wheelchair was positioned in front of two Qstraints (wheelchair tie down system) which connect to the front of the wheelchair. CW-A stated the Qstraints are able to secure to any area that is welded on the wheelchair. CW-A locked the wheelchair and placed the Qstraints on the welded underside of the wheelchair. CW-A then went to the back of the wheelchair and took the Qstraint system from the side of the van and placed on the Qstraint track on the floor of the van. CW-A stated the back Qstraints are not automatically set up like the front so the wheelchair can be brought into the van. After the four lower restraints are attached the seat belt is applied around the resident's middle and a shoulder strap is attached at a 45-degree angle appearing like a normal seatbelt. The driver should then perform a wiggle test on the wheelchair and resident to make sure the restraints were connected and secure. CW-A stated immediately after the incident on 5/22/26, he performed a post-incident inspection on the entire vehicle to ensure safety and performance of the system was good prior to allowing any other residents to ride in the van. During a follow-up interview on 6/4/26 at 2:03 p.m., CW-A stated on 5/22/26, he had performed a competency test watching VD-A place a resident in the Qstraint system without difficulties. CW-A stated all drivers were given a transportation guideline binder that has driving policies, instructions for how to secure residents in the van, and what to do in an emergency that they were supposed to keep with them. During a phone interview on 6/4/26 at 11:17 a.m., VD-A stated he had transported R1 and FM-A to an appointment on 5/22/26 and on the return drive to the facility he hit the brakes coming to a stoplight and R1 slid out of her wheelchair. VD-A stated he felt he was not trained properly. I have never secured a resident in a system like that before it is very complicated. VD-A stated if he were to come to the facility now he probably would not be able to secure it properly. VD-A stated the front wheelchair restraints were secured. The two on the back were crisscrossed and the seat belt came from the ceiling with a three-part system. VD-A stated he did the shake test after securing R1 in the Qstraint system. VD-A did not understand how R1 slid down out of the wheelchair under the seatbelt. After R1 slid out of the wheelchair, VD-A immediately put his flashers on and went to assess the situation. R1's rear end was almost on the floor and her legs were still under her like sitting cross legged almost. VD-A had FM-A assist him to get R1 back in the wheelchair by taking an arm and a leg each and hoisting R1 back into the wheelchair. VD-A reconnected the Qstraint system and drove to facility. After arriving at facility VD-A went to CW-A and explained the situation. VD-A stated after the incident he put in his resignation. A (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	phone call was placed to FM-A on 6/4/26 at 12:55 p.m. with no return call. During an interview on 6/4/26 at 1:13 p.m., certified physician assistant (PA)-C stated any fracture that happens when a person is older could lead to death. R1's fractures could lead to increased debility and decline. The facility had completed the following prior to the start of the survey: -In-service with all van drivers completed 5/26/26. - All residents who utilize the facility's transportation system were interviewed, and standardized investigative questions were asked.^ No additional concerns were identified. - All facility residents identified as being transported by the facility transportation vehicles in the past two weeks time had the following assessments completed with no identified concerns related to transportation services on 5/25/26: Skin Check Pain Assessment Safe Lifting and Movement Observations - All facility transportation vehicles were immediately placed out of service until a thorough safety inspection was completed on 5/26/26. - All facility transportation vehicles had daily inspection logs reviewed for completion for the past two-week period on 5/25/26. - Facility verified that all current transportation drivers had up to date education completed related to transportation services on 5/25/26. -All facility transportation drivers were reeducated on the following information on 5/26/26: Daily Vehicle Inspection Checklist Transportation Safety Transportation Competency Checklist Offsite Emergency Response (POL_IP100 Transportation & POL_AO020 Offsite Emergency Response Policy) Cornerstone Education Modules Vehicle Inspections and Driver Safety Wheelchair Transportation Safety -AP no longer employed at facility on 5/23/26.