Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: March 1, 2023

Dear Administrator:

On March 1, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 6, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 6, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Madison Healthcare Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered
March 22, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: 18G111

Dear Administrator:

The above facility was surveyed on February 27, 2023 through March 1, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

(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 2/27/23 through 3/1/23, 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 IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/27/23 through 3/1/23, 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: H53827116C (MN87516), H53827117C (MN878971), H53827118C (MN89380), H53828751C (MN91248) and H53828781C (MN90291). The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/30/2023

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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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Initial Pre-Admission Screening (PAS) for accuracy for 1 of 1 residents (R25) to ensure a level II screening was completed to identify if services were needed.	F 644	F644 Coordination of PASARR and Assessments SS=D 1. The corrective action taken to correct the deficiency is the Social Worker will ensure that a PASARR level 2 screening will be completed on all potential new	4/11/23

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F 644	Continued From page 2 Finding include: R25's 3/1/23, printed Admission Record identified R25 admitted on 11/15/23, that included admitting diagnoses of bipolar disorder with secondary diagnoses of depression, alcohol dependence, muscle weakness, and hypotension. R25's 11/22/21, admission Minimum Data Set (MDS) assessment identified in section A 1500 Pre-Admission Screening and Resident Review (PASRR) had the resident been evaluated for a level II screening and been determined to have a serious mental illness or related condition with the answer check as no. Section I 5900 of the MDS identified R25 had active diagnoses of Manic Depression (bipolar disease). Additionally, the following MDS's significant change 3/25/223, quarterly 5/18/22, and quarterly 8/17/22 had in section I active diagnoses of Manic Depression (bipolar) and Schizophrenia checked. Then the quarterly MDS's 11/16/22 and 2/15/23 under section I no longer had an active diagnoses of Schizophrenia but continued to have active bipolar disease. Review of the 11/15/21, PAS results identified R25 had no major mental disorder. Based on the information provided for the nursing home stay it appeared that R25 did not meet the criteria for mental illness (MI). Please note the final determination of the need for further evaluation will be made by Senior LinkAge Line. Senior LinkAge Line had forwarded the PAS to the county/managed care organization U-care for processing. Interview on 2/28/23 at 11:00 a.m., with director of	F 644	admissions that have a mental illness or developmental disorder. The DON has written a policy regarding PASARR screenings including the level 2 screening for people with mental illnesses or developmental disorders. SEE policy. 2. The measure that will be put into place to ensure the deficiency does not reoccur will be the Social Worker will track and audit the preadmission screenings on all admissions to determine if a level 2 screening is warranted. The Social Worker must obtain a complete list of all diagnoses prior to the preadmission screening. 3. The facility plans to monitor future performance to ensure the solution is sustained by the Social Worker bringing audits to QAPI committee meetings. All admissions will be audited monthly, and the audits will be discussed with the QAPI committee. The Social Worker will edit the admission checklist to include the pre-admission screening to ensure it is completed prior to admission and determine whether a level 2 screening is warranted based on present diagnoses. 4. The DON and Social Worker will be responsible for the corrective actions and monitoring of compliance. 5. The proposed date for compliance will be April 11, 2023.	

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F 644	Continued From page 3 nursing (DON) and social services designee (SSD) who both confirmed that the facility had no process for reviewing the PAS for accuracy compared to the residents admitting diagnoses. The DON revealed that the facility needed a process's to review the PAS for accuracy and bring that forward to the QAPI committee. The DON further revealed the facility needed a better process for maintaining PASRR results. The DON agreed by not ensuring the PAS was accurate and a level II screening was completed the facility may have missed pertinent services that the resident may have needed. A PASRR policy was requested, however the DON identified that the facility did not have one.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		4/11/23

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F 656	Continued From page 4 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plans for 2 of 2 residents (R25 and R30). Findings include: R25's 2/15/23, quarterly Minimum Data Set (MDS) assessment identified R25 had moderate cognitive impairment. R25 needed extensive assistance from 2 staff for bed mobility, transfers, and toileting. R25 was unable to balance on his own and needed staff assistance. R25 had no	F 656	ID Prefix Tag 2565 F656 SS=D Develop/Implement Comprehensive Care Plans 1. The corrective action that will be taken to correct the deficiencies is the DON will review and revise the comprehensive Care Planning Policy to ensure each resident has an individualized care plan that is specific to reflect their goals, wants, and needs. Care plans will be updated to reflect monitoring for target behaviors when a	

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F 656	Continued From page 5 behaviors noted during the assessment period. R25 was identified to take a daily antidepressant. R25 was identified to have Manic Depression (bipolar disease) and depression. The MDS lacked identification of the antipsychotic medication Invega Sustenna Suspension injection that R25 received each month. R25's 3/1/23, printed Order Summary Report identified Invega Sustenna Suspension Prefilled Syringe 39 mg/0.25 milliliters (ml) inject 39 mg intramuscularly the 21st of every month,an antipsychotic for bipolar, and Sertraline HCl 50 mg by mouth at bedtime, an antidepressant for bipolar. The orders lacked target behaviors for the medication or monitoring if the medications were effective. R25's 10/13/22, care plan identified R25 had a grab bar on his bed to aid in mobility. R25 required 1 staff assistance to transfer with an easy (EZ) stand. R25 was at risk for falls related to hypotension and psychoactive medication use. Staff were to ensure R25's call light was within reach and to provide prompt response to all R25's requests. The care plan identified that R25 may need reminding to use the call light. Staff were to assist R25 after eating to the bathroom and into his recliner as he often attempted self transfers. Observation and interview on 2/28/23 at 4:20 p.m., R25 was laying sideways on his bed, hand on his grab bar, feet hanging off the side of bed with call light laying at end of bed across the foot board. R25 was asked if he could reach his call light and he stated "no but that would be a good idea" at that time one surveyor stayed with R25 for safety and the other surveyor obtained facility	F 656	resident is prescribed an antipsychotic to ensure that the antipsychotic has been effective for the target behaviors. 2. Care center nursing staff will be educated on the new policy and the importance of following care plans by April 11, 2023. The DON or ADON will audit comprehensive care plans after admission to ensure they are created and implemented by 21 days after each new admission or when there has been a change in condition and the resident requires an update to their plan of care. Updates to the care plan are communicated to staff via the communication portal in Point Click Care and accessible at any time for staff to reference in the resident's Point Click Care chart. 3. The Interdisciplinary Team (DON, ADON, CCC, MDS Coordinator, Social Worker, Dietary Manager, and Activities Director) will form the new Care Plan Review Committee and review care plans every Thursday after resident care conferences take place that week to review those residents' care plans together as a team. CNAs attend the care conferences and will be asked for input regarding each resident's care plan. The resident and/or resident representative is encouraged to actively participate in the resident's care conference and provide input and/or care preferences to better ensure quality care that is specific to that resident. Any changes to the care plans are communicated to staff through the communication portal in Point Click Care. 4. The DON or ADON is responsible for	

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F 656	Continued From page 6 staff to assist R25. Licensed practical nurse (LPN)-A entered R25's room to assist R25 and confirmed that the call light was not within reach and should have been. R30 2/7/23, significant change Minimum Data Set (MDS) assessment identified R30 had severe cognitive deficit. R30 required extensive assistance with transfers and toileting. R30 took a daily antipsychotic, antidepressant, and antianxiety medication. R30 had behavior 1-3 days during assessment period that was not directed at other. R30 had 2 falls with no injury, 1 fall with minor injury, and 1 fall with major injury identified on the assessment. R30's 1/24/23, care plan identified R30 was at risk for falls and staff were to complete 30 minute checks, anticipate and meet needs, and staff were not to leave R30 in her room unattended unless she was in her recliner or bed. Observation on 2/27/23 at 12:52 p.m., R30 was sitting in her wheelchair in her room, yelling out "help". A facility staff member was obtained to assist R30 in her room. Interview on 2/28/23 at 5:59 p.m., with director of nursing (DON) identified her expectation was that all staff follow the residents care plans as written. The direct care staff were to review the resident care plans for changes at beginning of their shift. The DON revealed she had explained to staff that if the care plan was not followed and something happened to a resident from not following the care plan that there could be ramifications such as being reported to the nurse aide registry or board of nursing.	F 656	the corrective actions and monitoring for compliance. These audits will be discussed with the QAPI committee. 5. The proposed date for compliance is April 11, 2023.	

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F 656	Continued From page 7 Review of November 2023, Care Plans policy identified residents would have individualized care plans that addressed deficits that had been identified during the comprehensive assessment. Care plans will be reviewed and revised quarterly and as needed. There was no mention of how direct care staff would be informed of the care plan and/or any revisions to the care plan.	F 656		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify indications for the continued use of an as needed (PRN)	F 757	F757 Drug Regimen is Free from Unnecessary Drugs SS=D 1. The corrective action taken to correct	4/11/23

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F 757	Continued From page 8 antipsychotic medications, identify target behaviors, monitor for those behaviors, and identify non-pharmacological interventions for 2 of 2 residents (R13 and R25). Findings include: R13's 1/11/23, quarterly Minimum Data Set (MDS) assessment identified a diagnosis of depression and hallucinations. R13's cognition was noted to be severely impaired. R13 had feelings of being down and depressed, felt bad about themselves, felt they were a failure, and was noted by staff they felt they let themselves or their family down. R13 was noted to be also taking an antidepressant. R13's 2/21/23, medication administration record (MAR) identified R13 was to be administered Seroquel (antipsychotic), 25 milligrams (mg) twice daily, beginning 2/28/23 for hallucinations, Sertraline (anti-depressant) 50 mg once daily beginning 12/29/22 for depression, Haloperidol (antipsychotic) (aka Haldol), injection intramuscularly (IM) 5 mg every 8 hours as needed (PRN) and Haloperidol orally, 5 mg as needed every 8 hours PRN for aggressive behavior, both having a start date of 2/21/23. Lorazepam (anti-anxiety) 1 mg IM every 8 hours PRN for aggression or anxiety with a maximum daily dose of 3 mg was ordered, as well as lorazepam oral tablet, 1 mg every 8 hours PRN for aggression or anxiety maximum daily 3 mg, which was also started on 2/21/23. R13's 2/20/23, progress noted indicated R13 had attempted to elope, staff had intervened and assisted R13 away from the door. R13 then retrieved a "grabber" and was hitting the window.	F 757	the deficiencies is speaking with the provider and having him discontinue the prn antipsychotic from R13's drug regimen. R13 and R25 now have target behaviors added to their point of care daily and every shift documentation with interventions and outcomes. Monitoring for target behaviors has also been added to R13 and R25's plan of care with an individualized goal and interventions. The DON discussed with the Medical Director who is also the Primary Care Provider for R13 and R25 that perhaps emergent use of Haldol for a resident should only be a one time order and to request Thrifty White Drug to dispense Haldol in the Emergency Medication Kit that is stored in the medication room and available under the direction of a provider or that the medication only be administered in Emergency Department and the resident not return to the facility with a prn order for an antipsychotic. The Medical Director will educate other providers on the expectations of antipsychotic use. SEE Emergency Medication Kit Policy. 2. The measures that will be put into place to ensure the deficiency will not reoccur will be education to care center staff and providers regarding antipsychotic use and documentation of behaviors, regulations surrounding antipsychotics, ensuring that residents who are on antipsychotics are being monitored for target behaviors, and auditing the plan of care to ensure a focus to monitor for behaviors if an antipsychotic is started during their stay at the facility by the Care Plan Committee that will be developed.	

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F 757	Continued From page 9 The nursing staff attempted to redirect R13 but was unsuccessful. Nursing staff then called the physician who had offered to give an order for Haldol IM or they could transfer R13 to the emergency department (ED). The facility then transferred to the ED for further evaluation. R13's 2/21/23, pharmacy note identified R13 had a new order for Haldol which he reviewed from his ED visit to "help manage acute behavior...aggressive type, not effectively managed with non-pharmacological interventions...infection to be ruled out...discuss with nursing...will monitor". There was no indication what non-pharmacological interventions had been attempted prior to implementing an anti-psychotic. Further review of R13's progress notes identified there was no further mention of any aggressive behaviors to justify the continued emergent use of Haldol for behaviors that could not be managed with re-direction. There was also no mention, his care plan had been revised or updated to include when staff were to use emergent Haldol medication or what interventions for behaviors were to be tried before such use of Haldol would be indicated. R13's current, undated care plan identified R13 had a diagnosis of depression and received antidepressant medication. Staff noted R13 was to continue with 1:1 visits with his pastor as needed. There was no mention of any hallucinations or aggressive behaviors and lacked any indication of revision since R13's had a reported increase in aggressive behaviors. Observation on:	F 757	3. The facility will monitor future performance to ensure solutions are sustained by bringing future audits of care plans regarding behaviors to monthly QAPI committee meetings. Currently the MDS Coordinator is monitoring and auditing antipsychotic use among the residents and following up with the prescribing providers based on the recommendations of the consulting pharmacist. 4. The DON, CCC, and the MDS Coordinator will be responsible for the corrective actions and monitoring of compliance. 5. The proposed date for compliance will be April 11, 2023.	

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F 757	Continued From page 10 1) 2/27/23 at 12:44 p.m., identified R13 was sitting in dining room at the table sleeping and was disheveled in appearance. R13 had a plate in font of him with approximately 40% of the food eaten. An unknown staff member approached R13 to place his glasses on his face. R13 then ate a few more bites off his plate. When he was finished, he wheeled himself to the end of the hall-way near his room and sat, looking out the window. 2) 2/28/23 at 11:55 a.m., identified R13 was sitting in the dining room at the table alone, drinking juice and eating alone. 3) 3/1/23 at 8:53 a.m., identified R13 was sitting in his wheelchair in the dining room eating breakfast alone, watching staff and other residents as they walked by. At no time during the above observations was R13 conversing in a meaningful manner with other residents or staff, nor was there any outward signs of aggression leading to the need for emergent Haldol administration. Interview on 2/27/23 at 2:31 p.m. with family member (FM)-B identified he was aware R13 had been sent to the hospital and had been "acting out" with staff but eluded he was not able to come to the facility recently due to his own health problems. R13's 12/6/21, Mental Health Discharge Note identified R13 had completed his mental health treatment by showing increased improvement in his mood scores along with demonstrating the ability to maintain the use of coping skills, lessened behavior changes. Treatment was noted to have been "successful" and R13 had been discharged from their care. R13's medical record lacked any indication that R13 had any	F 757		

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F 757	Continued From page 11	F 757		

mental health treatment after 12/6/21, nor was there any indication, when R13 had emergent aggressive behaviors that his mental health provider had been notified.

R13's 3/1/23, medical record identified no behavioral assessment had been completed followig R13's return from the hospital with emergent anti-psychotic medication from his 2/20/23 ED visit.

Interview on 3/1/23 at 9:09 a.m., with nursing assistant (NA-C) identified R13's behaviors had started around the same time when he would have a urinary tract infection. NA-C would look at the care plan or kardex to identify what non-pharmacological interventions should be implemented when R13 exhibited any behaviors.

Interview on 3/1/23 at 10:00 a.m., with NA-D identified R13 has "threatened" staff and had yelled at staff but that she had no knowledge of R13 ever being physically aggressive. NA-D would have looked at the kardex for non-pharmacological interventions that should be attempted when R13 showed any behaviors.

Interview on 3/1/23 at 10:30 a.m., with licensed practical nurse (LPN-A) identified R13 had known behaviors of aggression with staff. Staff share information during shift report. When R13 would have had behaviors she would reference the care plan to identify effective intervention that could be used. She agreed any information identified in stand-up daily shift reports had not been placed into the care plan to educate staff at what to do if R13 showed any kind of behaviors.

Interview on 3/1/23 at 1:23 p.m., with director of

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F 757	Continued From page 12 nursing (DON) identified she was unaware R13 had an order for PRN antipsychotic Haldol. She would have expected staff would complete an appropriate behavioral assessment and revise the care plan identified non-pharmacological interventions to be used prior to using the emergent Haldol medication. The DON's expectation would be for nursing staff to have completed on-going behavioral assessments and document indications for the continued need of emergent medication or call the physician when the medication was not needed due to de-escalation of behavior. R25's 2/15/23, quarterly Minimum Data Set (MDS) assessment identified R25 had moderate cognitive impairment. R25 had no behaviors noted during the assessment period. R25 was identified to take a daily antidepressant and had a diagnosis of Manic Depression (bipolar disease). The MDS lacked identification of the antipsychotic medication Invega Sustenna (antipsychotic) that R25 received each month. R25's 3/1/23, Order Summary Report identified an order for a Invega Sustenna Suspension Prefilled Syringe 39 mg/0.25 milliliters (ml) inject 39 mg intramuscularly the 21st of every month and Sertraline HCl 50 mg by mouth at bedtime, an antidepressant for bipolar. The orders lacked target behaviors for the medication or monitoring if the medications were effective. R25's 10/13/22, care plan identified that R25 received antipsychotic medications for his bipolar disease and to monitor for for adverse reaction.	F 757		

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F 757	Continued From page 13 There was no mention of what the target behaviors were for the use of the psychoactive medicaion or monitoring for effectiveness. Interview on 2/28/23 at 5:59 p.m., with director of nursing (DON) identified her expectation was that resident care plans were individualized. She agreed that R25 had no identified target behaviors for the psychoactive medication he took and it would be hard to determine if the medication was working or not. She confirmed the facility did not know what the medication had been ordered for and agreed that the facility should have clarified what the target behaviors were upon admission in order to know if the medication was effective or not. Review of November 2023, Care Plans policy identified residents would have individualized care plans that addressed deficits that had been identified during the comprehensive assessment. Care plans will be reviewed and revised quarterly and as needed. There was no mention of how direct care staff would be informed of the care plan and/or any revisions to the care plan. There was no policy related to emergent anti-psychotic use provided by the end of the survey.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		4/11/23

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F 812	Continued From page 14 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure hair nets were accessible in 1 of 1 kitchenette located in the Harvest dining area and had the potential to effect 17 of 44 residents who were served food out of the kitchenette. The facility further failed to ensure 7 of 7 buttermilk containers had been discarded after expiration and failed to ensure 1 of 1 homemaker (HM)-B had appropriately secured her hair into her hairnet while serving food. Finding include: Observation on 2/27/23 at 11:37 a.m., of Homemaker (HM)-B prior and during the noon service identified they were standing behind a counter and would be dishing up and serving food in the Harvest Kitchenette. HM-B's hair net only covered her hair held in palace by a ponytail in the back. HM-B's hairnet did not secure the hair around her face which hung loose and downward over HM-B's cheeks and neck area during the entire meal service which could potentially contaminate resident's food.	F 812	ID Prefix Tag 21100 F812 SS=E Food Procurement, Store/Prepare/Serve-Sanitary 1. The corrective action taken to correct the deficiency is the Dietary Manager will review and revise policies and procedures for food storage in the dietary department and will provide appropriate training for all dietary and care center staff. The education will include information on the importance of physically checking dates and proper labeling on all items in refrigeration units and discarding accordingly during daily cleaning duties schedule and as needed to ensure expired items are not missed. The process for checking for expired items will now occur daily and dietary staff will initial a daily checklist after the task is completed. Hairnet dispensers have been purchased and will be installed in each kitchenette for easier access for staff to place over their entire head of hair upon entrance to the kitchens. Education and	

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F 812	Continued From page 15 Further observation and interview on 2/28/23 at 11:00 a.m., in the kitchen with cook-(A), identified the walk-in refrigerator had 7 quart sized cardboard containers of buttermilk that were expired with a date of 2/22/23. Staff were to check expiration dates weekly and "must have missed them". Cook-A agreed the buttermilk should have been discarded on the expiration date but it had not been used for meal prep after it had expired. Interview on 2/28/23 at 12:37 p.m., with dietary manager (DM) immediately after the noon meal service identified her expectation was hair nets were to be worn at all times with hair properly secured and not hanging down around the face uncovered. Staff were to discard any perishable items that were expired during their weekly cleaning process. Review of the February, 2023, Daily Cleaning Schedule for Cooks identified on Monday mornings, the cook was to clean the walk-in cooler and throw away any old or items that may have not been labeled appropriately. The cleaning schedule identified staff last cleaned the walk-in cooler on 2/27/23. There was no policy related to hair net use or labeling or discarding food after expiration provided by the end of the survey.	F 812	policy will be given to care center staff on importance of following the regulation of wearing hairnets appropriately in food prep areas. 2. The measures that will be put into place to ensure it does not reoccur will include auditing the refrigerators weekly for any expired food or unlabeled containers for four weeks or until 100 percent compliant and following up with staff that last initialed if any are found; then auditing monthly for three more months. Auditing staff for appropriate use of hairnets will be completed daily for four weeks and if 100 percent compliant will then audit weekly for an additional three months. 3. The Dietary Manager will bring audits to the QAPI committee meetings to review. 4. The Dietary Manager will be responsible for corrective actions and compliance. 5. The proposed date for compliance will be April 11, 2023.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		4/11/23

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F 880	Continued From page 16 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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	245382	A. BUILDING _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

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F 880	Continued From page 17 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure transmission based precautions (TBP) were followed by 1 of 1 dietary aide (DA)-A prior to entering R34's room. In addition, the facility failed to ensure appropriate whirlpool cleaning and disinfecting of 1 of 2 whirlpool tubs used for bathing which had the potential to affect 5 of 44 residents, R25, R18, R35, R5, R1, R37, and R34 who used the whirlpool tub. Findings include: TBP Observation on 2/27/23 at 6:28 p.m., with R34's room had a white personal protective equipment	F 880	ID Prefix Tag 21390 F880 SS=E Infection Prevention and Control Directed Plan of Correction (DPOC) Cohorting Residents/Transmission Based Precaution “Isolation” and PPE 1. “Observation on 2/27/23 with R34’s room had a white personal protective equipment (PPE) holder on the door. A sign indicated Contact Precautions hung outside the door prior to entrance. PPE required for any persons entering the room included a gown, gloves, and a mask. DA-A indicated she had understood the sign to don proper PPE but disregarded the sign because ‘she	

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F 880	Continued From page 18 (PPE) holder on the door. A sign indicated Contact Precautions hung outside the door prior to entrance. PPE required for any persons entering the room included a gown, gloves, and a mask. Observation on 2/27/23 at 6:30 p.m., of dietary aid (DA)-A identified DA-A was passing food trays and stopped at R34's door, looked at the sign, paused, and entered R34's room without donning a gown or gloves. Interview on 2/27/23 at 6:30 p.m., with DA-A indicated she had understood the sign to donn proper PPE, but disregarded the sign because she was "only passing food trays". DA-A stated she typically would have nurses give the food to residents on TBP, but failed to do on 2/27/23. DA-A received training on infection control and appropriate TBP with PPE, but had not worn PPE when entering R34's room due to her short height stating the gowns were "too big" and she would "trip and fall", as this had happened in previous months. Interview 2/27/23 at 6:40 p.m., with director of nursing (DON), identified her expectations of residents on transmission-based precautions (TBP) and use of appropriate PPE were to follow the instructions on the sign. DON also relayed that CNAs were to follow the manufacturing directions to disinfect the whirlpool tub. DON informed, if the staff didn't follow the instructions, she would first speak with them, and if it continued, she would reeducate them but said that nursing was the only ones with privileges to enter these rooms. Upon learning it was DA-A regarding proper PPE, DON indicated she would email her supervisor for re-education of DA-A.	F 880	was only passing food trays'. DA-A stated she typically would have nurses give the food to residents on TBP but failed to do so on 2/27/23. DA-A received training on infection control and appropriate TBP with PPE, but had not worn PPE when entering R34's room due to her short heigh stating the gowns were 'too big' and she would 'trip and fall', as this had happened in previous months." RCA and contributing factors to this deficient practice- 1) CNA(s) assigned to that hall were assisting in other dining rooms. 2) Gowns were too long for this staff member. • Corrective action will be accomplished by directing CNA(s) that are assigned to a particular neighborhood will pass trays to the rooms for that neighborhood. Staff will be aware who is on TBP on their neighborhood and will ensure that nursing takes the food order and passes the trays to those residents who are on TBP and will wear appropriate PPE for TBP residents. Dietary will update policy for their staff that prepare food not to enter rooms that are placed on TBP. SEE Infection Control Guidelines for Food Service Policy. • The facility identified other residents having the potential to be affected by the same deficient practice by noting that the staff person that entered the TBP room without PPE potentially affected the remaining residents on that hall by serving them their food. • PPE gowns of different length will be ordered by CSR to better accommodate employees of various sizes.	

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F 880	Continued From page 19 Review of the July, 2010, Standard and Isolation Transmission Based Precautions policy identified the use of PPE for Contact Precautions included wearing a gown, gloves, and mask protection prior to entering a resident' room. WHIRLPOOL TUB CLEANING Observation and interview on 3/1/23, at 11:02 a.m. with nursing assistant (NA)-A identified she began cleaning and disinfecting the whirlpool tub. NA-A applied gloves and demonstrated the process of how to clean and disinfect the tub following completion of a resident bath. NA-A noted she used Penner Classic Whirlpool disinfectant cleanser to disinfect the tub, bath chair, cushion and straps attached to the bath chair and poured in "a splash" of the solution into the tub. NA-A took a scrub brush and brushed over the interior surfaces of the tub, jets, chair with straps and cushion. NA-A continued the process for cleansing and disinfecting the tub, by scrubbing then pushed the Rinse Jets-button to allow the Penner Patient Care whirlpool disinfectant cleanser, to flow from the jets into the tub. NA-A, then left tub room to make R1's bed. All surfaces dried in approximately 1 minute. After 13 minutes NA-A returned, the drain was opened. NA-A then used the hand sprayer to rinse the tub and chair surfaces. NA-A had no instructions for cleaning and disinfecting the tub. NA-A was unaware of the appropriate amount of solution required, or the need to ensure the surfaces of the tub, chair, and straps remained wet with the disinfection solution for 10 minutes as directed to ensure disinfection was completed. Interview on 3/1/23, at 1:23 p.m., with NA-B, identified she also gave residents tub baths and	F 880	• Education on TBP, PPE, and Equipment will be provided to residents at the resident council meeting scheduled for April 19, 2023, at 2pm. • Education on TBP, PPE, and Equipment will be provided to families at the family council meeting scheduled for April 27, 2023, at 11am. • Education will be provided and completed by April 11, 2023 to all care center staff on PPE for residents who are on TBP. The education will include standard infection control practices, transmission based precautions, appropriate use of TBP, and donning and doffing of PPE. • All staff receive education and competency-based training on donning and doffing PPE upon hire at new employee orientation and at least annually thereafter. • The DON and Infection Preventionist will audit donning/doffing of PPE by staff when residents that are quarantined/isolated are requiring transmission-based precautions 4 times a week on every shift. (Currently we do not have any residents in isolation and/or requiring Transmission Based Precautions.) • These audits and RCA will be reviewed at the QAPI meeting scheduled for April 14, 2023 at 11am. • The facility has all single occupancy, private rooms, except for one double room that is occupied by a married couple per the request of the couple and their family, this couple would be the only residents that would cohort. There are no	

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F 880	Continued From page 20 was unaware of how much solution and wet contact time were required to appropriately disinfect the tub. Review of the 9/20/20, Tub Cleaning policy identified staff were to let the disinfectant remain on surface for 10 minutes. There was no mention the solution was to have a wet contact time of 10 minutes, nor did it identify to follow manufacturer's instructions for use of the disinfecting solution.	F 880	other plans to cohort residents. Residents can be isolated to their private room when needed for TBP. • SEE Current Infection Control Policy and the Precautions: Standard and Isolation Policy which has procedure for masks, gowns and gloves. Equipment/Environment 2. Whirlpool tub cleaning- “NA-A identified she began cleaning and disinfecting the whirlpool tub. NA-A applied gloves and demonstrated the process of how to clean and disinfect the tub following completion of a resident bath. NA-A noted she used Penner Classic Whirlpool disinfectant cleanser to disinfect the tub, bath chair, cushion, and straps attached to the bath chair and poured in “a splash” of the solution into the tub. NA-A took a scrub brush and brushed over the interior surfaces of the tub, jets, chair with straps and cushion. NA-A continue the process for cleansing and disinfecting the tub, by scrubbing then pushed the Rinse Jets-button to allow the Penner Patient Care whirlpool disinfectant cleanser, to flow from the jets into the tub. NA-A, then left tub room to make R1's bed. All surfaces dried in approximately 1 minute. After 13 minutes NA-A returned, the drain was opened. NA-A then used the hand sprayer to rinse the tub and chair surfaces. NA-A had no instructions for cleaning and disinfecting the tub. NA-A was unaware of the appropriate amount of solution required, or the need to ensure the surfaces of the tub, chair, and straps remained wet with the disinfection solution	

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F 880	Continued From page 21	F 880	for 10 minutes as directed to ensure disinfection was completed. Interview on 3/1/23, at 1:23 p.m., with NA-B, identified she also gave residents tub baths and was unaware of how much solution and wet contact time were required to appropriately disinfect the tub. Review of the 9/20/20, Tub Cleaning policy identified staff were to let the disinfectant remain on surface for 10 minutes. There was no mention the solution was to have a wet contact time of 10 minutes, nor did it identify to follow manufacturer's instructions for use of the disinfecting solution." RCA and contributing factors to this deficient practice- 1) Tub Cleaning policy not readily available in tub room. 2) Manufacturer's instructions not available in this tub room to reference by staff. 3) Staff did not return and rewet the surface of the tub and tub chair with straps after one minute. 4) Staff not aware that surfaces can dry quickly and then the kill time of the disinfectant is not effective. • Corrective action will be accomplished for those residents found to have been affected by the deficient practice by updating the Tub Cleaning Policy to reflect what the manufacturer's instructions state and placing the Tub Cleaning Policy in each tub room so that it is readily available for staff to reference when cleaning the tub after each resident use. • Tub Cleaning Policy updated to reflect that the disinfectant is to remain wet on the surfaces for ten minutes and that staff need to check every minute to ensure it stays wet for the full ten minutes. Tub	

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F 880	Continued From page 22	F 880	Cleaning Policy also updated to reference Penner Manufacturing Instruction Manual. SEE Tub Cleaning Policy. • The facility will identify other residents having the potential to be affected by the same deficient practice by having a list of residents that prefer a bath and which tub they take their bath in. • Staff will be educated by the DON or ADON in the proper tub cleaning process with competencies by April 11, 2023. • The DON, ADON, or Infection Preventionist(IP) will audit the cleaning and disinfecting of tubs 4 times every week on all shifts if applicable until 100% compliant, then monthly for 3 months. • The DON, ADON, or IP will review the results of the audits with the QAPI committee.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/27/23 through 3/1/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 565, 1100, 1390. Please indicate in your electronic plan of	2 000		

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

Electronically Signed | 03/30/23

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2 000	Continued From page 1 correction that you have reviewed these orders, and identify the date when they will be completed. The following complaint(s) were reviewed during the survey with no licensing orders issued: H53827116C (MN87516), H53827117C (MN87897), H53827118C (MN89380), H53828751C (MN91248), and H53828781C (MN90291). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plans for 2 of 2 residents (R25 and R30). Findings include: R25's 2/15/23, quarterly Minimum Data Set (MDS) assessment identified R25 had moderate cognitive impairment. R25 needed extensive assistance from 2 staff for bed mobility, transfers, and toileting. R25 was unable to balance on his own and needed staff assistance. R25 had no behaviors noted during the assessment period. R25 was identified to take a daily antidepressant. R25 was identified to have Manic Depression	2 565	Corrected	4/11/23

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2 565	Continued From page 3 (bipolar disease) and depression. The MDS lacked identification of the antipsychotic medication Invega Sustenna Suspension injection that R25 received each month. R25's 3/1/23, printed Order Summary Report identified Invega Sustenna Suspension Prefilled Syringe 39 mg/0.25 milliliters (ml) inject 39 mg intramuscularly the 21st of every month,an antipsychotic for bipolar, and Sertraline HCl 50 mg by mouth at bedtime, an antidepressant for bipolar. The orders lacked target behaviors for the medication or monitoring if the medications were effective. R25's 10/13/22, care plan identified R25 had a grab bar on his bed to aid in mobility. R25 required 1 staff assistance to transfer with an easy (EZ) stand. R25 was at risk for falls related to hypotension and psychoactive medication use. Staff were to ensure R25's call light was within reach and to provide prompt response to all R25's requests. The care plan identified that R25 may need reminding to use the call light. Staff were to assist R25 after eating to the bathroom and into his recliner as he often attempted self transfers. Observation and interview on 2/28/23 at 4:20 p.m., R25 was laying sideways on his bed, hand on his grab bar, feet hanging off the side of bed with call light laying at end of bed across the foot board. R25 was asked if he could reach his call light and he stated "no but that would be a good idea" at that time one surveyor stayed with R25 for safety and the other surveyor obtained facility staff to assist R25. Licensed practical nurse (LPN)-A entered R25's room to assist R25 and confirmed that the call light was not within reach and should have been.	2 565		

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2 565	Continued From page 4 R30's 2/7/23, significant change Minimum Data Set (MDS) assessment identified R30 had severe cognitive deficit. R30 required extensive assistance with transfers and toileting. R30 took a daily antipsychotic, antidepressant, and antianxiety medication. R30 had behavior 1-3 days during assessment period that was not directed at other. R30 had 2 falls with no injury, 1 fall with minor injury, and 1 fall with major injury identified on the assessment. R30's 1/24/23, care plan identified R30 was at risk for falls and staff were to complete 30 minute checks, anticipate and meet needs, and staff were not to leave R30 in her room unattended unless she was in her recliner or bed. Observation on 2/27/23 at 12:52 p.m., R30 was sitting in her wheelchair in her room, yelling out "help". A facility staff member was obtained to assist R30 in her room. Interview on 2/28/23 at 5:59 p.m., with director of nursing (DON) identified her expectation was that all staff follow the residents care plans as written. The direct care staff were to review the resident care plans for changes at beginning of their shift. The DON revealed she had explained to staff that if the care plan was not followed and something happened to a resident from not following the care plan that there could be ramifications such as being reported to the nurse aide registry or board of nursing. Review of November 2023, Care Plans policy identified residents would have individualized care plans that addressed deficits that had been identified during the comprehensive assessment. Care plans will be reviewed and revised quarterly	2 565		

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2 565	Continued From page 5 and as needed. There was no mention of how direct care staff would be informed of the care plan and/or any revisions to the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing and/or revising a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created, and/or revised and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure hair nets were accessible in 1 of 1 kitchenette located in the Harvest dining area and had the potential to effect 17 of 44 residents who were served food out of the kitchenette. The	21100	Corrected	4/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

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21100	Continued From page 6 facility further failed to ensure 7 of 7 buttermilk containers had been discarded after expiration and failed to ensure 1 of 1 homemaker (HM)-B had appropriately secured her hair into her hairnet while serving food. Finding include: Observation on 2/27/23 at 11:37 a.m., of Homemaker (HM)-B prior and during the noon service identified they were standing behind a counter and would be dishing up and serving food in the Harvest Kitchenette. HM-B's hair net only covered her hair held in palace by a ponytail in the back. HM-B's hairnet did not secure the hair around her face which hung loose and downward over HM-B's cheeks and neck area during the entire meal service which could potentially contaminate resident's food. Further observation and interview on 2/28/23 at 11:00 a.m., in the kitchen with cook-(A), identified the walk-in refrigerator had 7 quart sized cardboard containers of buttermilk that were expired with a date of 2/22/23. Staff were to check expiration dates weekly and "must have missed them". Cook-A agreed the buttermilk should have been discarded on the expiration date but it had not been used for meal prep after it had expired. Interview on 2/28/23 at 12:37 p.m., with dietary manager (DM) immediately after the noon meal service identified her expectation was hair nets were to be worn at all times with hair properly secured and not hanging down around the face uncovered. Staff were to discard any perishable items that were expired during their weekly cleaning process.	21100		

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21100	Continued From page 7 Review of the February, 2023, Daily Cleaning Schedule for Cooks identified on Monday mornings, the cook was to clean the walk-in cooler and throw away any old or items that may have not been labeled appropriately. The cleaning schedule identified staff last cleaned the walk-in cooler on 2/27/23. There was no policy related to hair net use or labeling or discarding food after expiration provided by the end of the survey. SUGGESTED METHOD FOR CORRECTION: The Dietary Director could review and revise policies and procedures for reviewing food storage in the Dietary department and provide appropriate training for involved staff. The Director could rotinely monitor the system to assure food is appropriately stored and/or discarded according the facility policy. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21100		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an	21390		4/11/23

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21390	Continued From page 8 immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure transmission based precautions (TBP) were followed by 1 of 1 dietary aide (DA)-A prior to entering R34's room. In addition, the facility failed to ensure appropriate whirlpool cleaning and disinfecting of 1 of 2 whirlpool tubs used for bathing which had the potential to affect 5 of 44 residents, R25, R18, R35, R5, R1, R37, and R34 who used the whirlpool tub. Findings include: TBP Observation on 2/27/23 at 6:28 p.m., with R34's room had a white personal protective equipment (PPE) holder on the door. A sign indicated Contact Precautions hung outside the door prior to entrance. PPE required for any persons entering the room included a gown, gloves, and a mask.	21390	Corrected	

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21390	Continued From page 9 Observation on 2/27/23 at 6:30 p.m., of dietary aid (DA)-A identified DA-A was passing food trays and stopped at R34's door, looked at the sign, paused, and entered R34's room without donning a gown or gloves. Interview on 2/27/23 at 6:30 p.m., with DA-A indicated she had understood the sign to donn proper PPE, but disregarded the sign because she was "only passing food trays". DA-A stated she typically would have nurses give the food to residents on TBP, but failed to do on 2/27/23. DA-A received training on infection control and appropriate TBP with PPE, but had not worn PPE when entering R34's room due to her short height stating the gowns were "too big" and she would "trip and fall", as this had happened in previous months. Interview 2/27/23 at 6:40 p.m., with director of nursing (DON), identified her expectations of residents on transmission-based precautions (TBP) and use of appropriate PPE were to follow the instructions on the sign. DON also relayed that CNAs were to follow the manufacturing directions to disinfect the whirlpool tub. DON informed, if the staff didn't follow the instructions, she would first speak with them, and if it continued, she would reeducate them but said that nursing was the only ones with privileges to enter these rooms. Upon learning it was DA-A regarding proper PPE, DON indicated she would email her supervisor for re-education of DA-A. Review of the July, 2010, Standard and Isolation Transmission Based Precautions policy identified the use of PPE for Contact Precautions included wearing a gown, gloves, and mask protection prior to entering a resident' room.	21390		

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21390	Continued From page 10 WHIRLPOOL TUB CLEANING Observation and interview on 3/1/23, at 11:02 a.m. with nursing assistant (NA)-A identified she began cleaning and disinfecting the whirlpool tub. NA-A applied gloves and demonstrated the process of how to clean and disinfect the tub following completion of a resident bath. NA-A noted she used Penner Classic Whirlpool disinfectant cleanser to disinfect the tub, bath chair, cushion and straps attached to the bath chair and poured in "a splash" of the solution into the tub. NA-A took a scrub brush and brushed over the interior surfaces of the tub, jets, chair with straps and cushion. NA-A continued the process for cleansing and disinfecting the tub, by scrubbing then pushed the Rinse Jets-button to allow the Penner Patient Care whirlpool disinfectant cleanser, to flow from the jets into the tub. NA-A, then left tub room to make R1's bed. All surfaces dried in approximately 1 minute. After 13 minutes NA-A returned, the drain was opened. NA-A then used the hand sprayer to rinse the tub and chair surfaces. NA-A had no instructions for cleaning and disinfecting the tub. NA-A was unaware of the appropriate amount of solution required, or the need to ensure the surfaces of the tub, chair, and straps remained wet with the disinfection solution for 10 minutes as directed to ensure disinfection was completed. Interview on 3/1/23, at 1:23 p.m., with NA-B, identified she also gave residents tub baths and was unaware of how much solution and wet contact time were required to appropriately disinfect the tub. Review of the 9/20/20, Tub Cleaning policy identified staff were to let the disinfectant remain on surface for 10 minutes. There was no mention the solution was to have a wet contact time of 10	21390		

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21390	Continued From page 11 minutes, nor did it identify to follow manufacturer's instructions for use of the disinfecting solution. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure clear directions for staff to follow regarding infection control practices, specific to isolation processes when providing cares to residents to minimize the spread of infection. The Director of nursing or designee could assure staff are trained, randomly monitored, supervised and systems evaluated to assure good infection control practice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 4, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: March 1, 2023

Dear Administrator:

On March 22, 2023, we notified you a remedy was imposed. On April 12, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 11, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 6, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 22, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 11, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 4, 2023

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: Reinspection Results
Event ID: 18G112

Dear Administrator:

On April 12, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 1, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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