Electronically delivered

May 28, 2020

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

SUBJECT: SURVEY RESULTS
CCN: 245382
Cycle Start Date: March 4, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 7, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Madison Healthcare Services to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the March 4, 2020 survey. Madison Healthcare Services may choose to delay

submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the March 4, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
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Fax: 507-537-7194

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting

immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Madison Healthcare Services may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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 _____	05/07/2020

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 A COVID-19 Focused Infection Control survey was conducted on 5/5/20 through 5/7/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 5/5/20 through 5/7/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880	Infection Prevention & Control	F 880		5/8/20

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

Electronically Signed | 06/04/2020

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 880 SS=F	Continued From page 1 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 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	F 880		

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F 880	Continued From page 2 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 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, interview, and document review the facility failed to actively screen employees prior to entry or appropriately train staff on signs and symptoms of COVID-19 in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. Finding include:	F 880	F 880 Infection Prevention and Control The facility did not meet requirement due to not actively screening employees prior to entry or appropriately train staff on signs and symptoms of COVID-19 in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19.	

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F 880	Continued From page 3 Observation on 5/5/20 at 9:25 a.m., of the main entrance to the health care facility identified a table was located in the area immediately inside the first set of double doors. On that table was hand sanitizer, screening forms, and masks. Observation and interview on 5/5/20 at 9:32 a.m.,with maintenance staff (M)-B identified he approached the screening table inside the main entrance of the building, had no mask on and he took his own temperature and documented it on the screening form. He was to check his temperature each day upon arrival to the facility. He was required to wear a source control mask in resident area's. M-B identified contracted workers or visitors were to enter through the main entrance. Staff normally entered the facility from a back staff entrance. The staff entrance required them to enter the facility, walk around a corner where business offices and proceed down the hall to a table inside the front main entrance. Located at this table was a thermometer, binder containing all staff screening forms, and hand sanitizer. Observation and interview on 5/5/20 at 10:00 a.m., with nursing assistant (NA)-A identified staff were to screen themselves when coming into work prior to entering resident areas. She had came on duty at 5:30 a.m. and donned a mask, but was late for shift and had forgotten to screen herself by taking her temperature and complete screening form prior to working with the residents. NA-A identified she had reviewed the information related to symptoms of COVID-19 but could not recall specific information. She had received training on use of personal protective equipment (PPE) and hand washing but could not recall the date. NA-A was informed of COVID-19	F 880	Plan of Correction: May 8, 2020 or prior to employees next shift, all Madison Healthcare Services employees in all departments were educated on active screening upon entry to the facility. Active screening is defined as having a trained screener obtain temperature and symptom check. Staff were educated that they are no longer able to self temp or screen. Trained screener has completed the symptom check and temperature screening process competency. All employees were educated and updated on the signs and symptoms of COVID-19 in accordance with the CDC and CMS. Infection Preventionist is the central oversite for any new changes that come from MDH or CDC or CMS and is responsible to inform the Incident Command Team. Communication plan for the new information will be discussed and planned on how to disperse it to the rest of the staff. Each department will be responsible to have employees sign off on knowing the change/update. Audits will be conducted by the Infection Preventionist to assure that all staff are being actively screened upon entrance to the facility. The audits will occur weekly x 4 weeks and monthly thereafter. Audit results will be presented to the QAPI committee. QAPI will document this in the meeting minutes and will decide the need to continue monitoring.	

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symptoms, but had only been aware of the limited information identified on the self-screening form and was unable to identify additional signs or symptoms of COVID-19.

Interview on 5/5/20 at 12:50 p.m., with dietary manager (DM) identified that a staff member in her department had tested positive for COVID-19 on 5/1/20, cook (C)-A had worked her full shift on 4/25/20, with no mention of not feeling well. DM identified C-A had not reported any signs or symptoms of illness to anyone in the dietary department that day. She identified C-A had not been scheduled to work on 4/26/20, and 4/27/20. On 4/28/20 at 1:21 a.m., DM received a text message from C-A identifying she could not make her shift. C-A had reported feeling ill, had body aches and had vomited. Further interview on 5/7/20 at 10:24 a.m., with DM identified she came into work on 4/28/20 but did not inform anyone of C-A's symptoms or that she had called in sick. The DM notified the IP at 10:00 a.m., of C-A call-in and symptoms who then contacted the triage nurse at the clinic. The DM identified she had not attended COVID-19 meetings. She received her information for COVID-19 updates via email. The DM was not updated of the new COVID-19 symptoms from CDC, and was unaware C-A's symptoms were associated with COVID-19. Staff received COVID-19 updates in an orange communication binder at the screening table located at the front entrance and via reading material on the computer. The DM was unable to identify who had reviewed the COVID-19 updates because staff were not expected to sign the reviewed information. Her expectation was for staff to review the information provided on the screening table before starting their shift.

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Interview on 5/5/20 at 1:12 p.m., with dietary aides DA-A and DA-B identified both self-screen. Both said they received no formal training, only emails. For staff who do not read emails they would not know about the training. Neither DA-A nor DA-B were aware of reportable signs or symptoms for COVID-19.

Interview on 5/5/20 at 1:18 p.m., with the chief financial officer (CFO), identified she completed a self-screen upon entry to work. She was unaware of the COVID-19 signs and symptoms to identify. The CFO identified it would be helpful if the information was listed on the screening form.

Interview on 5/5/20 at 1:20 p.m., with housekeeping supervisor (HK)-A identified the facility protocol was for staff to self screen and if their temperature was above 99.0 degrees Fahrenheit (F) they should not enter the building.

Interview on 5/5/20 at 1:27 p.m., with licensed practical nurse (LPN)-A identified if a staff person had a temperature above 100.3 F when they self screened they were to notify the DON, contact the doctor and probably receive a virtual visit.

Interview on 5/5/20 at 3:23 p.m., with the director of nursing (DON) identified anyone with a fever above 100.0 F, a cough, or who had been around someone with COVID-19 would not enter the building but would go to their car and call their supervisor. DON identified staff were to find communication or updates in the orange binder or on point click care (PCC) under communication. DON identified training on use of the thermometer was located in the orange binder or on PCC. The DON identified she and the administrator had investigated the need to meet

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and greet staff when they entered the facility and their findings were, it was not necessary and staff were permitted to self screen. Her expectation was that staff were self-screening upon entering the facility for their shift.

Interview on 5/5/20 at 3:57 p.m., with administrator identified his expectation was for all employees to self screen upon entering the facility. He sought consultation regarding staff screening, and determined self-screening was adequate.

Interview on 5/6/20 at 1:15 p.m., with cook (C)-A identified on 4/25/20, she arrived at work, screened herself and began her shift. C-A identified she had felt tired on 4/25/20, had a loss of appetite, and had general nausea. She felt those were her usual symptoms for her menstrual cycle. She was able to work her full shift on 4/25/20 despite not feeling well. On 4/28/20 at 1:21 a.m., her symptoms worsened and she developed body aches and vomited. The triage nurse (RN) contacted her the afternoon of 4/28/20, to review symptoms and informed her she would need to go in for a COVID-19 test and scheduled a time. On 5/1/20, she received the positive COVID-19 test results. C-A identified she had not been educated in regards to the signs and symptoms of COVID-19 other than what was listed on the screening form. She had not received training on the screening process. She only knew what she learned on the television and what signs and symptoms were on the screening form for COVID-19 symptoms. C-A identified she had followed directions for taking her temperature and answered the four questions on the form. She was unaware she needed to report the occurrence of symptoms on 4/25/20, consisting of

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headache, nausea, tiredness, and loss of appetite as she was not aware these could be symptoms of COVID.

Review of COVID-19 screening book identified C-A's 4/25/20, self-screening form identified: her temperature was 97.4 degrees Ferenheiht (F). C-A checked "no" to identify she had no contact with anyone confirmed with and/or suspected COVID-19, or anyone with respiratory illness. C-A denied respiratory infection (cough, shortness of breath, sore throat). C-A checked she had not traveled out of the country, or resided in a community with known cases of COVID-19. At the bottom of the form was a notation "If you are self-monitoring, notify your manager of any of the signs and symptoms above. If you are at work with symptoms present, notify your manager." No additional symptoms of COVID-19 were included on the form.

Interview on 5/6/20 at 1:24 p.m., with nursing assistant (NA)-B identified she had received training on wearing a mask and protective gear. NA-B further identified she was unaware of what would happen if she became ill during work.

Interview on 5/6/20 at 5:15 p.m., with the DON identified she had only provided training to the nursing department. Other departments were expected to provide their own training or arrange it with the IP. The DON identified it was each staff's responsibility to review the list of symptoms on the outside of the screening binder and review the orange binder for updates. The DON further explained the department supervisor was responsible to ensure staff knew what the signs and symptoms of COVID-19 were, and when they were restricted from work. The DON had not

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F 880	Continued From page 8 overseen the process for training or ensuring staff were actively screened. There was no documentation to support the DON or administrator had performed any oversight to ensure compliance. Interview on 5/7/20 at 9:14 a.m., with the Infection Preventionist (IP) identified she was aware that staff were expected to screen themselves prior to entering the building and caring for residents. Staff were to take their own temperature and complete a four question form. The forms were located in an binder on a table inside front entrance door. IP identified she had not provided the training to staff on how to screen themselves or on the signs and symptoms of COVID-19. The IP was unaware of who or how often staff screening sheets were reviewed. She identified employee screening questions were not current and she had not been involved in the creation of the form. She identified COVID-19 meetings were held three times a week, but did not include all departments. The IP identified the dietary manager and activity manager did not attend. She identified each department manager is responsible for providing training to staff in their department. The IP identified there was no training packet available for COVID-19 which included signs and symptoms, or detailed the screening process for employees. She received updated information weekly from listening to the long term care (LTC) calls every Wednesday. Interview on 5/7/20 at 12:49 p.m., with medical director (MD)-A identified staff should be actively screened upon entry to facility. He agreed someone who had symptoms would be identified through an active screening process. MD-A felt the facility may have struggled to implement	F 880		

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active screening due to staffing issues and work schedules he was aware of. MD-A agreed facility management needed to have oversight of all COVID-19 activities to ensure each staff was trained appropriately and followed policies and procedures.

Interview on 5/7/20 at 2:00 p.m., with director of environmental services (ES) identified that in the past there had been an educator in charge of staff training but those duties had been delegated to the department managers. He identified it would be beneficial to have an education coordinator that could work with the infection control preventionist at this time to improve the training and implementation of protocols. He identified currently his training had mostly been provided by the ambulance service, of which he was a member. He identified that the training material he provided to staff in his department came from the Department of Health (MDH) or Centers for Disease Control and Prevention (CDC). He ensured staff in the environmental service department signed and dated updates after they were reviewed.

Review of the 3/16/20, all staff memo identified staff were to report to the DON prior to the start of their shift to review the process for COVID-19 screening. The memo included four screening questions and how to measure a temperature. An electronically created staff list with nursing department names and dates of training completion was included. Review of the nursing department list identified NA-A was not included in the list to verify she received training. No additional documents were provided to identify all staff were trained to screen for the additional COVID-19 symptoms identified by the CDC, and

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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
F 880	Continued From page 10 to report them to the IP or DON if symptoms were present. Review of the 4/20/20, Madison Healthcare Services Coronavirus (COVID-19) policy identified the goal was to reduce transmission, protect healthcare personnel, decrease mortality and preserve the functions of healthcare. The policy identified staff were to self-monitor by taking their temperature every shift and document it. Staff were to notify their supervisor of the development of symptoms including fever and/or respiratory symptoms. The policy made no mention of the parameters and made no mention of what the respiratory symptoms were. Additionally, the policy did not include additional symptoms identified by the CDC. Copies of communication emails from management to staff had been requested but not provided.	F 880		