Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 2024

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, a survey was completed at your facility by the Minnesota Departments 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 attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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
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 _____	11/06/2024

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 11/4/24 through 11/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and 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, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/4/24 thruogh 11/6/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT 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. 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 substantial compliance with the regulations has been attained.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		12/9/24

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

Electronically Signed | 12/10/2024

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 636	Continued From page 1 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff	F 636		

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F 636	Continued From page 2 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow their policy and complete an Abnormal Involuntary Movement (AIMS) assessment for 1 of 5 residents (R31) who had been administered an antipsychotic. Findings include: R31's 8/16/24, quarterly Minimum Data Set (MDS) assessment identified he had diagnosis of non- traumatic brain dysfunction, Alzheimer's disease, and depression. R31's cognition was severely impaired, he required supervision with walking and extensive assistance with toileting and personal hygiene. R31's current diagnosis list identified on 8/6/24, he received a new diagnosis of severe episode of recurrent major depressive disorder, with	F 636	ID Prefix Tag F636 SS=D Comprehensive Assessments “Based on observation, interview, and document review, the facility failed to follow their policy and complete an Abnormal Involuntary Movement (AIMS) assessment for 1 of 5 residents (R31) who had been administered an antipsychotic.” RCA and contributing factors to this deficient practice- 1) The facility failed to complete an AIMS assessment on 1 of 5 residents who were administered an antipsychotic medication. Corrective action will be accomplished immediately by the following: 1. An AIMS assessment was completed on R31 upon discovery of the assessment	

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F 636	Continued From page 3 psychotic features. R31's 8/29/24, physician order form identified R31 started taking olanzapine (anti-psychotic medication) 5 milligrams (mg) by mouth daily at bedtime on 8/29/24. R31's 10/31/24 outpatient detail report identified the physician increased R31's olanzapine to 10 mg every morning. R31's 9/13/24, care plan identified he takes an antipsychotic with interventions to complete an AIMS assessment per facility policy and as needed. R31's September 2024, medication administration record (MAR), identified he was administered olanzapine 10 mg daily. Review of R31's assessments completed since admission identified no AIMS assessment had been completed. Interview on 11/6/24 at 8:22 a.m., with the MDS coordinator identified an AIMS assessment was to be completed upon the start of an antipsychotic medication. The nurse who transcribed the order was to complete the initial AIMS assessment and schedule the next AIMS assessment in 30 days. The assessment should be completed with any changes in dose, and 30 days after the new medication started. She reviewed R31's chart and agreed he had not had an AIMS assessment completed. Interview on 11/6/24, at 8:17 a.m., with the pharmacist consultant identified he would expect the facility to complete an AIMS assessment	F 636	not being completed on 11/7/2024. 2. DON verbally educated pharmacist consultant on 12/3/2024 regarding reviewing AIMS completion upon initiation of an antipsychotic, a dose change, and 30 days after the order is initiated. The pharmacist consultant confirmed this is on the form in which is used to audit medication records. 3. Under direction of the DON, the RN Clinical Care Coordinator will audit the facility dashboard in PointClickCare at minimum, one time a week, to ensure all residents who receive orders for antipsychotics have an AIMS assessment completed upon initiation of the antipsychotic, if a dosage is changed, and 30 days after the order is initiated. 4. The RN MDS Coordinator performed an audit on 12/9/2024 of all antipsychotics prescribed for current residents since January 1, 2024 to ensure all are up to date with an AIMS assessment. 5. The RN Clinical Care Coordinator will report at the facility's monthly QAPI meeting the completion rate of the AIMS assessments until 100% completion for six months. 6. Assessment education was added to the facility's Nurse Orientation Checklist. 7. A communication was posted in PointClickCare to all nurses reminding them of the facility policy that states an AIMS assessment is to be completed on every resident at the initiation of an antipsychotic medication order, the change of a dose, and 30 days thereafter. 8. This plan was put in place and completed by 12/9/2024.	

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F 636	Continued From page 4 when starting an antipsychotic. He identified the assessment is used to determine if the resident is having side effects of extrapyramidal movement (involuntary movements), in this case the medication may need to be changed or discontinued before worsening. Review of the July 2024, Psychotropic Drug Monitoring policy identified nursing staff were to complete an assessment for Tardive Dyskinesia which is the AIMS assessment for: 1) Baseline target behavior before an antipsychotic had begun or upon admission. 2) When a new antipsychotic medication was added or the dose had been changed. 3) At 6 months for re-evaluation.	F 636		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a portable oxygen (O2) tank (E-cylinder) was safely secured for 1 of 4 residents (R21). Findings include: Observation and interview on 11/04/24 at 12:52 p.m. with R21 identified he was alert and oriented	F 689	ID Prefix Tag F689 SS=D Free of Accidents Hazards/Supervision/Devices "Based on observation, interview, and record review, the facility failed to ensure a portable oxygen (O2) tank (E-cylinder) was safely secured for 1 of 4 residents (R21)." RCA and contributing factors to this deficient practice- 1) The facility failed to	12/31/24

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F 689	Continued From page 5 and was seated on the edge of his bed with oxygen on at 2 liters (L) per minute (M) via a nasal cannula (NC) connected to an oxygen concentrator. Two oxygen tanks were observed, one of which was in a portable stand with a regulator attached and one sitting unsecured on the floor in addition to a small black portable oxygen carrier were noted to be at the end of the dresser visible upon entry to the room. R21 reported he used oxygen when he was in his room, and used the portable tanks if he went to an appointment or left the building. R21 reported the oxygen tanks were left in his room for his use when he needed them and had been left there since he had been admitted. R21 was admitted to the facility in August 2024 with diagnoses of pulmonary fibrosis, cerebral infarction, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), PTSD, major depressive disorder, and generalized anxiety disorder. R21's current physician orders identified but the current electronic physician orders identified staff were to check oxygen saturation (O2 sat) every shift, and apply O2 via NC 1-3 LPM as needed (PRN) as needed when O2 sat less than 90%. Observation of R21 on 11/04/24 at 7:03 p.m. noted R21 seated in his recliner watching TV in a darkened room with O2 on via NC. The O2 tanks remained in the same location with the one tank resting on the floor in an upright position unsecured. He reported he was not aware the unsecured tank was a problem and identified his O2 tanks were routinely left sitting in his room in that location since he had been admitted.	F 689	ensure a portable oxygen (O2) tank (E-cylinder) was safely secured for 1 of 4 residents. Corrective action will be accomplished immediately by the following: 1. The oxygen tank was immediately removed from R21's room and placed in the designated oxygen storage room in a cylinder rack. 2. The facility's Oxygen Services policy was updated to state the following: ¿ Safe Handling and Storage • Oxygen canisters will be stored in the designated oxygen storage room in a cylinder rack. • An oxygen canister outside of the designated oxygen storage room will be stored in an oxygen cart. 3. A sign was placed in R21's room to remind all staff that oxygen tanks are not to be left outside of a cylinder rack and/or an oxygen cart. 4. Audits performed by DON, MDS Coordinator, Clinical Care Coordinator, and Scheduler will be performed two times weekly and PRN on all residents who utilize oxygen canisters and compliance rate will be reported at the facility's monthly QAPI meeting until the 100% for six months. 5. Staff on duty upon discovery of the unsecured oxygen tank were educated regarding the policy update and safe handling of oxygen tanks. 6. All staff will be educated on the policy update and proper storage by 12/31/24. 7. This plan was put in place and will be completed by 12/31/2024.	

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F 689	Continued From page 6 Interview on 11/04/24 at 7:05 p.m. with licensed practical nurse (LPN)-A identified when O2 tanks were not in use they should be stored in the oxygen supply closet, and if they were in a resident space they needed to be positioned either in an oxygen cart or in a holder located on the resident's wheelchair. She reported oxygen tanks were not supposed to be left unsecured sitting in a resident room and she was not aware of the unsecured tank in R21's room. Interview on 11/4/24 at 7:10 p.m., with the director of nursing (DON) who accompanied this surveyor to R21's room confirmed one of the two O2 cylinders was standing unsecured on the floor of R21's room and it should not have been left there. O2 tanks were to be kept in a stand or wheelchair holder and it was not acceptable to leave a tank unsecured. A policy on O2 use and monitoring was requested, but the DON reported they did not have a current policy for Oxygen use in the long term care (LTC) setting.	F 689		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 5 of 8 staff (administrator, director of nursing (DON), registered nurse (RN)-A, RN-C, and trained medication aide	F 949	ID Prefix Tag F949 SS=E Behavioral Health Training “Based on interview and document review the facility failed to ensure 5 of 8 staff	12/31/24

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F 949	Continued From page 7 (TMA)-A) received annual training and 1 of 1 newly hired staff nursing assistant (NA-B) received initial training on Alzheimer's disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. This had the potential to affect all the residents in the facility. Findings include: Review of the administrators personnel file identified a hire date of 9/28/12. Review of his Alzheimer's training records identified he had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 9/30/22. The administrator training record lacked identification that he had completed training on Alzheimer's disease and related disorders annually. Review of the DON's personnel file identified a hire date of 11/01/21. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 9/28/22. The DON training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for RN-A identified a hire date of 8/04/20. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 10/25/22. RN-A's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually.	F 949	(administrator, director of nursing (DON), registered nurse (RN)-A, RN-C, and trained medication aide (TMA)-A) received annual training and 1 of 1 newly hired staff nursing assistant (NA-B) received initial training on Alzheimer's Disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. This had the potential to affect all the residents in the facility. RCA and contributing factors to this deficient practice- 1)The facility failed to ensure that 5 of 8 staff had received training on Alzheimer's Disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. Corrective action will be accomplished by the following: 1. The DON will report at the facility's monthly QAPI meeting the completion rate of staff for CARES Training until100% for six months. 2. All care center staff will have completed four hours of CARES Dementia training by 12/31/2024. 3. The facility purchased an annual subscription of CARES Dementia training on 11/12/2024. 4. Human Resources has added CARES Dementia training to the mandatory education upon orientation for new employees. 5. Four hours of CARES Dementia training will be required annually going forward along with other mandatory	

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F 949	Continued From page 8 Review of the personnel file for RN-C identified a hire date of 2/16/23. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 2/16/23. RN-C's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for TMA-A identified a hire date of 8/16/18. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 11/28/22. TMA-A's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for NA-B identified a hire date of 10/15/24. Review of his training record lacked identification that he had not completed training on Alzheimer's disease and related disorders upon hire. Review of July 2024 Facility Assessment identified the facility would provide staff training, education, and competencies necessary to provide support and care needed for the resident population and to ensure knowledge competency for all staff. The facility would provide education and training in person, online, and other various formats. Lastly, staff competencies would be verified upon orientation, annually, and as needed. Interview on 11/06/24 at 9:57 a.m. with DON identified she was aware that staff had not all completed Alzheimer/Dementia training. She stated the facility was awarded a grant to help	F 949	training delivered via electronic method.	

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 _____	11/06/2024

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
F 949	Continued From page 9 facilitate the training for all staff, previously. In addition, the facility had opted not to purchase the course on an annual basis and was in the process of purchasing new education software for 2025 and would plan for staff to complete the training for new hires and on an annual basis. Request a copy of In-service Training policy and none was provided.	F 949		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/05/2024. At the time of this survey, Madison Healthcare Services was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 12/10/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

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MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE** **MADISON, MN 56256**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Madison Healthcare Services Nursing Home is a 3-story building with partial basement, and is fully fire sprinkler protected. The original building was constructed in 1914 and was determined to be of Type I(322) construction. The 1952 addition was determined to be of Type I(332) construction. The 1968 addition was determined to be of Type II(111) construction. The 1977 addition was determined	K 000		

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

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MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE** **MADISON, MN 56256**

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K 000	Continued From page 2 to be of Type II(111) construction. The 1991 addition was determined to be of Type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The 1914 and 1952 buildings are a "B" Occupancy. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 45 at the time of the survey.	K 000		
K 324 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		12/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

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MADISON HEALTHCARE SERVICES	**900 SECOND AVENUE** **MADISON, MN 56256**

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K 324	Continued From page 3 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(8), and NFPA 96 (2010 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.10. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 11/05/2024 between 9:30 and 11:15 AM, it was revealed by observation that there was not a Class K extinguisher installed in the South Kitchenette. An interview with the Maintenace Director verified this deficient finding at the time of discovery.	K 324	K324 Cooking Facilities SS=E 1. The corrective action taken to correct the deficiency is that Madison Healthcare Services has ordered and will install a K Class Fire Extinguisher in the south neighborhood kitchenette. 2. The measures that will be put into place to ensure the deficiency does not reoccur is this has been added to the maintenance monthly fire extinguisher checklist. Once the Fire Extinguisher is installed this should not reoccur. 3. The Maintenance Department plans to monitor and report to the Facilities Supervisor to ensure the solution is sustained. 4. The Maintenance Department and Facilities Supervisor are responsible for the corrective actions and monitoring of compliance. 5. This deficiency for the south neighborhood kitchenette will be corrected in a timely matter after the Fire Extinguisher arrives.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **02 - MADISON HEALTHCARE SERVICES** B. WING _____	**11/05/2024**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/05/2024. At the time of this survey, Madison Healthcare Services Bldg. 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **02 - MADISON HEALTHCARE SERVICES** B. WING _____	**11/05/2024**

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Madison Healthcare Services Nursing Home Building 02 is a 1-story building with no basement, and is fully fire sprinkler protected Constructed in 2020 and completed in 2021. Construction type is determined to be Type II (000) and has an attic space that has a dry sprinkler system.	K 000		

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K 000	Continued From page 2 The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire extinguishers per NFPA	K 324	K324 Cooking Facilities SS=E 1. The corrective action taken to correct	12/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **02 - MADISON HEALTHCARE SERVICES** B. WING _____	**11/05/2024**

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K 324	Continued From page 3 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(8), and NFPA 96 (2010 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.10. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 11/06/2024 between 9:30 and 11:15 AM, it was revealed by observation that there was not a Class K extinguisher installed in either Kitchenette in the North Wing. An interview with the Maintenace Director verified this deficient finding at the time of discovery.	K 324	the deficiency is that Madison Healthcare Services has ordered and will install a K Class Fire Extinguisher in both north neighborhood kitchenettes. 2. The measures that will be put into place to ensure the deficiency does not reoccur is this has been added to the maintenance monthly fire extinguisher checklist. Once the Fire Extinguishers are installed this should not reoccur. 3. The Maintenance Department plans to monitor and report to the Facilities Supervisor to ensure the solution is sustained. 4. The Maintenance Department and Facilities Supervisor are responsible for the corrective actions and monitoring of compliance. 5. This deficiency for the north neighborhood kitchenettes will be corrected in a timely matter after the Fire Extinguishers have arrived.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the	K 920		12/16/24

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	245382	A. BUILDING **02 - MADISON HEALTHCARE SERVICES** B. WING _____	**11/05/2024**

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K 920	Continued From page 4 patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.1.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, section 400.8(1). This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 11/05/2024 between 9:30 and 11:15 AM, it was revealed observation that in the IT Room in the north end of the building, an orange extension cord was being used to supply power to a relocatable power tap. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 Electrical Equipment SS=D 1. The corrective action taken to correct the deficiency is that Thole Electric will install a 2-gang outlet in the IT Closet for exterior building lighting controls. This is scheduled for 12 December 2024. 2. The measures that will be put into place to ensure the deficiency does not reoccur is this has been added to the maintenance safety rounding checklist. Once the outlet is installed this should not reoccur. 3. The Maintenance Department plans to monitor and report to the Facilities Supervisor to ensure the solution is sustained. 4. The Maintenance Department and Facilities Supervisor are responsible for the corrective actions and monitoring of compliance. 5. This deficiency for the IT Room in the north end of the building will be corrected on 12 December 2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 2024

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: State Nursing Home Licensing Orders
Event ID: QRF111

Dear Administrator:

The above facility was surveyed on November 4, 2024 through November 6, 2024 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 Dahl, RN, Regional Operations Supervisor
Marshall District Office
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
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
	00329	A. BUILDING: _____ B. WING _____	11/06/2024

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) COMPLETE DATE
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 11/4/24 through 11/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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 _____	11/06/2024

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2 000	Continued From page 1 identify the date when they will be completed. 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 surveyors 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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 be corrected prior to electronically submitting to the Minnesota Department of Health. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a portable oxygen (O2) tank (E-cylinder) was safely secured for 1 of 4 residents (R21). Findings include: Observation and interview on 11/04/24 at 12:52 p.m. with R21 identified he was alert and oriented and was seated on the edge of his bed with oxygen on at 2 liters (L) per minute (M) via a nasal cannula (NC) connected to an oxygen concentrator. Two oxygen tanks were observed, one of which was in a portable stand with a regulator attached and one sitting unsecured on the floor in addition to a small black portable oxygen carrier were noted to be at the end of the dresser visible upon entry to the room. R21 reported he used oxygen when he was in his room, and used the portable tanks if he went to an appointment or left the building. R21 reported the oxygen tanks were left in his room for his use when he needed them and had been left there since he had been admitted. R21 was admitted to the facility in August 2024	2 270	Corrected	11/6/24

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2 270	Continued From page 3 with diagnoses of pulmonary fibrosis, cerebral infarction, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), PTSD, major depressive disorder, and generalized anxiety disorder. R21's current physician orders identified but the current electronic physician orders identified staff were to check oxygen saturation (O2 sat) every shift, and apply O2 via NC 1-3 LPM as needed (PRN) as needed when O2 sat less than 90%. Observation of R21 on 11/04/24 at 7:03 p.m. noted R21 seated in his recliner watching TV in a darkened room with O2 on via NC. The O2 tanks remained in the same location with the one tank resting on the floor in an upright position unsecured. He reported he was not aware the unsecured tank was a problem and identified his O2 tanks were routinely left sitting in his room in that location since he had been admitted. Interview on 11/04/24 at 7:05 p.m. with licensed practical nurse (LPN)-A identified when O2 tanks were not in use they should be stored in the oxygen supply closet, and if they were in a resident space they needed to be positioned either in an oxygen cart or in a holder located on the resident's wheelchair. She reported oxygen tanks were not supposed to be left unsecured sitting in a resident room and she was not aware of the unsecured tank in R21's room. Interview on 11/4/24 at 7:10 p.m., with the director of nursing (DON) who accompanied this surveyor to R21's room confirmed one of the two O2 cylinders was standing unsecured on the floor of R21's room and it should not have been left there. O2 tanks were to be kept in a stand or wheelchair holder and it was not acceptable to	2 270		

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2 270	Continued From page 4 leave a tank unsecured. A policy on O2 use and monitoring was requested, but the DON reported they did not have a current policy for Oxygen use in the long term care (LTC) setting. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen equipment is maintained in a safe and secure manner. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those findings to QAPI until compliance is achieved. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include:	2 302		12/31/24

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2 302	Continued From page 5 (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 5 of 8 staff (administrator, director of nursing (DON), registered nurse (RN)-A, RN-C, and trained medication aide (TMA)-A) received annual training and 1 of 1 newly hired staff nursing assistant (NA-B) received initial training on Alzheimer's disease or related disorders, assistance with activities of daily living (ADL), problem solving with challenging behaviors, and communication skills. This had the potential to affect all the residents in the facility. Findings include: Review of the administrators personnel file identified a hire date of 9/28/12. Review of his Alzheimer's training records identified he had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 9/30/22. The administrator training record lacked identification that he had completed	2 302	Corrected	

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2 302	Continued From page 6 training on Alzheimer's disease and related disorders annually. Review of the DON's personnel file identified a hire date of 11/01/21. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 9/28/22. The DON training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for RN-A identified a hire date of 8/04/20. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 10/25/22. RN-A's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for RN-C identified a hire date of 2/16/23. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 2/16/23. RN-C's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for TMA-A identified a hire date of 8/16/18. Review of her Alzheimer's training records identified she had completed training on ADL care, communication needs, and behaviors and obtained a certificate on 11/28/22. TMA-A's training record lacked identification that she had completed training on Alzheimer's disease and related disorders annually. Review of the personnel file for NA-B identified a	2 302		

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2 302	Continued From page 7 hire date of 10/15/24. Review of his training record lacked identification that he had not completed training on Alzheimer's disease and related disorders upon hire. Review of July 2024 Facility Assessment identified the facility would provide staff training, education, and competencies necessary to provide support and care needed for the resident population and to ensure knowledge competency for all staff. The facility would provide education and training in person, online, and other various formats. Lastly, staff competencies would be verified upon orientation, annually, and as needed. Interview on 11/06/24 at 9:57 a.m. with DON identified she was aware that staff had not all completed Alzheimer/Dementia training. She stated the facility was awarded a grant to help facilitate the training for all staff, previously. In addition, the facility had opted not to purchase the course on an annual basis and was in the process of purchasing new education software for 2025 and would plan for staff to complete the training for new hires and on an annual basis. Request a copy of In-service Training policy and none was provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The	2 302		

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2 302	Continued From page 8 administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status;	2 540		11/6/24

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2 540	Continued From page 9 H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow their policy and complete an Abnormal Involuntary Movement (AIMS) assessment for 1 of 5 residents (R31) who had been administered an antipsychotic. Findings include: R31's 8/16/24, quarterly Minimum Data Set (MDS) assessment identified he had diagnosis of non- traumatic brain dysfunction, Alzheimer's disease, and depression. R31's cognition was severely impaired, he required supervision with walking and extensive assistance with toileting and personal hygiene. R31's current diagnosis list identified on 8/6/24, he received a new diagnosis of severe episode of recurrent major depressive disorder, with psychotic features. R31's 8/29/24, physician order form identified R31 started taking olanzapine (anti-psychotic medication) 5 milligrams (mg) by mouth daily at bedtime on 8/29/24. R31's 10/31/24 outpatient detail report identified the physician increased R31's olanzapine to 10 mg every morning.	2 540	Corrected	

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2 540	Continued From page 10 R31's 9/13/24, care plan identified he takes an antipsychotic with interventions to complete an AIMS assessment per facility policy and as needed. R31's September 2024, medication administration record (MAR), identified he was administered olanzapine 10 mg daily. Review of R31's assessments completed since admission identified no AIMS assessment had been completed. Interview on 11/6/24 at 8:22 a.m., with the MDS coordinator identified an AIMS assessment was to be completed upon the start of an antipsychotic medication. The nurse who transcribed the order was to complete the initial AIMS assessment and schedule the next AIMS assessment in 30 days. The assessment should be completed with any changes in dose, and 30 days after the new medication started. She reviewed R31's chart and agreed he had not had an AIMS assessment completed. Interview on 11/6/24, at 8:17 a.m., with the pharmacist consultant identified he would expect the facility to complete an AIMS assessment when starting an antipsychotic. He identified the assessment is used to determine if the resident is having side effects of extrapyramidal movement (involuntary movements), in this case the medication may need to be changed or discontinued before worsening. Review of the July 2024, Psychotropic Drug Monitoring policy identified nursing staff were to complete an assessment for Tardive Dyskinesia which is the AIMS assessment for: 1) Baseline target behavior before an	2 540		

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2 540	Continued From page 11 antipsychotic had begun or upon admission. 2) When a new antipsychotic medication was added or the dose had been changed. 3) At 6 months for re-evaluation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required data assessments specific to the resident. The director of nursing or designee should educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 9, 2025

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: November 6, 2024

Dear Administrator:

On January 8, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 9, 2025

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: Reinspection Results
Event ID: QRF112

Dear Administrator:

On January 8, 2025 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 November 6, 2024. 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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us