#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

	_		_		AND TRANSMIT FE SURVEY AGI			ID: TNDA Facility ID: 00329	
MEDICARE/MEDICAID PROVI (L1) 245382     STATE VENDOR OR MEDICAIL (L2) 134242800		3. NAME AND ADDRESS OF FACILITY (L3) MADISON HEALTHCARE SERVIC (L4) 900 SECOND AVENUE (L5) MADISON, MN		CES (L6) 5625	56	<ol> <li>Initial</li> <li>Termination</li> </ol>	6. Complaint	2. Recertification 4. CHOW	
5. EFFECTIVE DATE CHANGE O (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>08/2017</b> (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEG  05 HHA  06 PRTF  07 X-Ray  08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	14 CORF	CLIA	7. On-Site Vis 8. Full Survey FISCAL YEAR I 12/31	y After Complaint ENDING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATI From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKE 18 SNF 18/19 SN 65 (L37) (L38)  16. STATE SURVEY AGENCY RE  17. SURVEYOR SIGNATURE  Gail Anderson, HFE N	65 (L18) 65 (L17) DOWN F 19 SNF (L39)	Compliance1. A B. Not in Comp Requirements  ICF  (L42)  ABLE SHOW LTC CA  Date:	nnce With equirements e Based On: cceptable POC liance with Progra and/or Applied V  IID  (L43)	nm Vaivers: DATE):	And/Or Approved V  2. Technical  3. 24 Hour I  4. 7-Day RN  5. Life Safet  * Code: A  15. FACILITY MEE  1861 (e) (1) or 186	Personnel RN I (Rural SN) y Code ITS I (j) (1):	6. Scope 7. Medic F) 8. Patien 9. Beds/I (L12) (L15)	e of Services Limit cal Director at Room Size Room  Date:	(L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	` ′	OFFICE OR SI	NGLE ST	FATE AGENC		(L20)
19. DETERMINATION OF ELIGIE  _X 1. Facility is Eligible to 2. Facility is not Eligible	o Participate		IPLIANCE WITH	I CIVIL	2. Owner			A-2572) • Stmt (HCFA-1513)	
22. ORIGINAL DATE  OF PARTICIPATION 12/01/1986  (L24)  25. LTC EXTENSION DATE:  (L27)	-	G DATE	4. LTC AGREEM ENDING DATE (L25) (L44) (L45)		26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W 03-Risk of Involuntary 04-Other Reason for V	Reimburse	05-F ment 06-F n <u>OTF</u> 07-P	(L30)  OLUNTARY ail to Meet Health/Safety ail to Meet Agreement  IER trovider Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
AL DO DECEME OF CHICAGO	(L28)	03001	LOE ABBROWA	(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF AFFRUVAL	DALE					

(L33)

DETERMINATION APPROVAL

09/25/2017

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245382

October 11, 2017

Mr. Justin Hughes, Administrator Madison Healthcare Services 900 Second Avenue Madison, MN 56256

Dear Mr. Hughes:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective August 29, 2017 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: <u>mark.meath@state.mn.us</u>

Phone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 11, 2017

Mr. Justin Hughes, Administrator Madison Healthcare Services 900 Second Avenue Madison, MN 56256

RE: Project Number S5382026

Dear Mr. Hughes:

On August 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2017, effective August 29, 2017 and therefore remedies outlined in our letter to you dated August 10, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	111	DΑ		
Faci	lity	ıD.	ഹ	320

		10 22 00::11					1 demity 12: 00029	
MEDICARE/MEDICAID PROVID     (L1) 245382	ER NO.	3. NAME AND AI (L3) <b>MADISON</b> I			CES	4. TYPE OF ACTI	ON: <u>2 (L8)</u> 2. Recertification	
2.STATE VENDOR OR MEDICAID	NO.	(L4) 900 SECON	D AVENUE			3. Termination	4. CHOW	
(L2) <b>134242800</b>		(L5) MADISON,	MN		(L6) <b>56256</b>	5. Validation	6. Complaint	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit	9. Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Aft	er Complaint	
6. DATE OF SURVEY 07/2	<b>0/2017</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR END	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requires	nents:	
To (b):		_	equirements		2. Technical Personne	6. Scope of S	Services Limit	
		Compliance	e Based On:		3. 24 Hour RN	7. Medical I	Director	
12.Total Facility Beds	<b>65</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI	NF) 8. Patient Ro	om Size	
13.Total Certified Beds	<b>65</b> (L17)	X B. Not in Con	nnliance with Pro	aram	5. Life Safety Code	9. Beds/Room	m	
13. Total Certifica Beas	(==-)		and/or Applied	-	* Code: <b>B*</b>	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN	I.			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	<b>YES</b> (L15)		
65								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	TARKS (IF APPLICA	BLE SHOW LTC CA	ANCELL ATION	DATE):				
10. SIME SURVET MOLIVET REV	nuus (n mi Lier	ABLE SHOW ETC CI	I VELLERII IOI V	DML).				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Susan Bachleitner, HFE	NEII		08/16/2017	(L19)	Mark Meath.	Enforcement Specia	09/25/2017 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI		L OFFICE OR SINGLE S	STATE AGENCY	(L20)	
19. DETERMINATION OF ELIGIBI			IPLIANCE WIT		21. 1. Statement of Fina		572)	
V 1 Facility is Eligible to	Dortioinata	RIGHTS ACT:			2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
<ul><li>X 1. Facility is Eligible to</li><li>2. Facility is not Eligible</li></ul>	-				3. Both of the Abov	e:		
2. Pacinty is not Englor	(L21)							
22. ORIGINAL DATE	23. LTC AGREE!	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	ſ:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	<u>0</u> <u>involu</u>	JNTARY_	
12/01/1986					01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER		
		n of Admissions:			04-Other Reason for Withdrawal	· · · · · · · · · · · · · · · · · · ·	der Status Change	
	-		(L44)			00-Activ	e	
(L27)	B. Rescind St	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINATION APP	PROVAL		
				/	ZZIZIGIII WIII ON WIII	, <u></u>		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 10, 2017

Mr. Justin Hughes, Administrator Madison Healthcare Services 900 Second Avenue Madison, MN 56256

RE: Project Number S5382026

Dear Mr. Hughes:

On July 20, 2017, a standard 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### **DEPARTMENT CONTACT**

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 29, 2017, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 29, 2017, the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

#### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

### 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 October 20, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if

deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

PRINTED: 08/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245382	B. WING _	<del></del>	07	/20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SEF	RVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000 F 279 SS=D	as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility rassessments compand the in the residence of the assessments of th	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.  acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with	F 00	0		8/29/17
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial in comprehensive ass	e Care Plans  It develop and implement a reson-centered care plan for sistent with the resident rights $O(c)(2)$ and §483.10(c)(3), that alle objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive scribe the following -				
LABORATOR	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

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.

**Electronically Signed** 

08/14/2017

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		245382	B. WING		0	7/20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CO 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	or maintain the resi physical, mental, ar required under §48.  (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §4.  (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's representation of the provide and the resident's provide and the resident of the resident's provide and the resident of the resi	t are to be furnished to attain dent's highest practicable of psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).  services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.  with the resident and the tative (s)- goals for admission and  preference and potential for acilities must document at's desire to return to the sessed and any referrals to ies and/or other appropriate	F2	79		
	(C) Discharge plans plan, as appropriate requirements set fo section. This REQUIREMENT by:	s in the comprehensive care e, in accordance with the rth in paragraph (c) of this NT is not met as evidenced ion, interview and document		The facility will develop and	implement	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	` ,	E SURVEY PLETED
		245382	B. WING _		07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SEF	RVICES		STREET ADDRESS, CITY, STATE 900 SECOND AVENUE MADISON, MN 56256	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	which identified chr residents (R4) revises kin concerns.  Findings include:  A quarterly Minimum 6/2/17, revealed R4 hemiplegia, depress of anticoagulants (Ithad moderate imparequired extensive Activity of Daily Livit transferring, and to R4's care plan revises the potential for implication included hands and body pare Keep fingernails should compliant, keep he recliner. Educate recausative factor an injury. Identify/doc factors and eliminate Keep skin clean and Pressure redistributed in the recliner. Weekly slendings and report care plan did not actinity interventions.  Care conference med continued to had declined follow up to the skin continu	ailed to develop a care plan ronic facial lesions for 1 of 3 gwed for non-pressure related a had diagnoses which include sion, aphasia, long-term use plood thinning medication), and aired cognition. The resident assist of one person with ng including bed mobility, ileting.  Seed 7/24/14, identified "I have pairment to skin integrity. Ided, avoid scratching and keep rts from excessive moisture. Fort. Booties to heels, when els floated when in bed or esident/family/caregivers of d measures to prevent skin ument potential causative te /resolve where possible. If dry. Use lotion on dry skin, tion cushion in wheelchair and kin inspections, document to provider as needed. The ddress facial lesions and onte dated 5/31/17, indicated we cancer lesions on face, with surgeon to discuss	F 2		al-centered care ied, individualized rehensive lity residents. On R4 s care plan include a ressure cancer difference and resident so A goal has been iver lesions and implemented plan will be individually be individually and implemented plan will be individually be individually and implemented plan will be reviewed all identified needs the highest level of incompleted on an audits of the pleted monthly to ance.  The control of the pleted incomplete incomplete, will inpletting audits of incompleting au	
	used hydrocortison	Further, the note indicated R4 e to decrease itching and and scratching areas. The				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245382	B. WING		07	/20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP ( 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 279	note identified R4's self-administered the R4's current physic directed the adminicream. apply tid (the lesions. patient mathematics Physician progress R4 had facial lesion and questioned if the induced. The physician progress sore on his right cheat been there for indicated R4 tender left cheek sore had slightly. Left lower (centimeter) x 1.0 consultation without ulceration, so The physician documost likely basal consultation visit delikely had 3 areas of surgical options with with no treatment the slow progression. It is lesions have been plast four years without appointment was sand his wife refused.	skin at risk and indicated R4 ne hydrocortisone cream.  ian orders signed 6/29/17, stration of hydrocortisone 1% ree times per day) to facial by have in his room.  note dated 9/23/16, indicated ns that he tended to pick at, ney were chronic or selfician believed it was most note dated 1/12/17, R4 had a leek and lower left cheek, and quite some time. The note of to pick at his sores, and the progressed and worsened cheek measured 1.0 cm cm x 0.5 cm ulcerated area. aling, mild erythema, edema or cheek. Right lesions is skin breakdown or drainage. Imented the skins lesions were sell carcinoma, and would have regery for excision.  ated 1/20/17, indicated R4 of cancer of his face, discussed the R4 and education was given ne areas would likely have the note indicated R4's present for approximately the out resolution. Follow-up cheduled for 2/3/17, which R4	F 2	79		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION  NG			PLETED
		245382	B. WING	<del></del>		07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CO 900 SECOND AVENUE MADISON, MN 56256	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE
F 279	for possible lesion roption. R4 request lesions daily, and copicking the facial lecream to be applied lesions was ordered he may have that m. Physician progress R4 was to continue cream to the lesion surgery and was reremoved but R4 deany type of interven hydrocortisone 1% times per day.  Physician progress R4 was able to see facial lesion, but de Indicated he does nat this time. Contin 1% cream to affecte Physician progress R4 was seen by the his facial lesions, an observation, cryothwith freezing. R4 e performed. R4 has carcinoma, suspect that diagnosis: how performed. 2 freezon each lesion, R4 and recommended weeks for continue	consultation visit with surgery removed, and deferred that ed a cream to use on his facial continued with anxiety and sions. Hydrocortisone 1% of three times daily to facial d. R4 was given the order that nedication in his room.  note dated 5/5/17, indicated using the Hydrocortisone 1% son his face. R4 was seen by commended to have them clined and continues to defer ation. Continue to use cream to affected areas two  note dated 6/29/17, indicated surgery about his left sided ferred all options given to him. Not want anything further done use to use the hydrocortisone ed areas twice per day.  note dated 7/19/17, indicated a general surgeon in regards to and discussed options including erapy, excision, and excision lected to have cryotherapy a history of basal cell tesions are consistent with ever, no biopsy has been e thaw cycles were performed tolerated the procedure well, to return to the clinic again 8	F 2	79			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		E SURVEY IPLETED
		245382	B. WING	····	07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE
F 279	the area was shiny. There were other rewhich we intact. Reface and stated the reported the spots. On 7/19/17, at 7:17 wheelchair in the disores on his face, oright cheek, and on his nose. R4 also wareas of redness in On 7/19/17, at 7:42 open areas on his finformed R4 he had for the doctor to locular of the doctor of the doct	s left cheek next to his nose, and weeping clear liquid. ed areas around R4's nose 4 touched the areas on his y did not bother him, and come and go.  a.m. R4 was observed in a ning room, and had multiple one open area on his left and e open area on the left side of was observed to have multiple these areas.  a.m. R4 was pointing to the ace, clinical manager (CM)-Ad an appointment at 9:00 a.m. ok at his sores.  p.m. the assistant director of livered a completed noncondition assessments for R4 ADON reported the er had been discontinued  1.6 cm-open area, covered cryotherapy, n x 2.4 cm, flat red a 2.0 cm 5.0 cm, open area  7.0 x 4.0 with a 2.0 mm depth	F 2	79		

-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245382	B. WING _		07	//20/2017
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP COD 900 SECOND AVENUE MADISON, MN 56256		,,
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	around his face who present. R4 stated he did agree it was R4 indicated the soface for quite some 7/17/17, at 4:58 p.1 areas on his face of there now for a london On 7/19/17, at 11:4 (LPN)-B confirmed worked with R4 free a picker, and had a lesions alone. LPN the facial lesions, to fhealing or how lepresent on R4's factome and go, then LPN-B reported R4 while back and R4 the sores.  On 7/19/17, at 11:5 plan lacked any dochronic facial lesion interventions, CM-identity this concernor of 20/20/17, at 11:42 (DON) confirmed some sand the report of the was at high risk his anticoagulation.  The facility's care prindicated all residentices in the sores.	the sores did not bother him, a hard for him to not pick them. Ores had been present on his etime. When interviewed on m. R4 and his wife reported the come and go, and have been g time.  18 a.m. licensed practical nurse a she was R4's nurse today and quently. LPN-B stated R4 was a hard time leaving the facial N-B could not confirm size of the description, the progression ong the lesions had been ce. LPN-B stated the sores stated the sores were cancer. If had been to the doctor a and family decided not to treat and family decided not to treat a.m. the director of nursing the would expect these skin tesident's chronic picking to ed on his care plan, and stated given his co-morbidities with use as well.	F 27	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245382	B. WING		07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 279 F 309 SS=D	Continued From pa comprehensive ass 483.24, 483.25(k)(I FOR HIGHEST WE	essments. PROVIDE CARE/SERVICES	F 2			8/29/17
	applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste	e undamental principle that and services provided to facility sident must receive and the ethe necessary care and maintain the highest I, mental, and psychosocial ent with the resident's essment and plan of care.				
	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pre practice, the compr	fundamental principle that lent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including				
	provided to residen consistent with prof the comprehensive	ent. Issure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences.				
	residents who requ services, consisten of practice, the com	cility must ensure that ire dialysis receive such t with professional standards aprehensive person-centered residents' goals and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245382	B. WING		07/:	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SEF	RVICES	9	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	This REQUIREMED by: Based on observareview, the facility freoccurring facial s (R4) reviewed for monditions.  Findings include: A quarterly Minimum 6/2/17, revealed Rahemiplegia, depressof anticoagulants (I had moderate imparequired extensive Activity of Daily Livit transferring, and to Care conference on R4 continued to had declined follow up possible removal. used hydrocortison reduce him picking note identified R4's self-administered to R4's current physic directed the adminicream. apply tid (the lesions. Patient materials and the potential for implications indicated the potential for implications indicated the excessive monditions in the potential for implications in the po	NT is not met as evidenced tion, interview and document ailed to identify and monitor kin lesions for 1 of 1 resident from pressure related skin  m Data Set (MDS) dated that diagnoses which include the sion, aphasia, long-term use colood thinning medication), and aired cognition. The resident assist of one person with ing including bed mobility,	F 309	Each resident will receive the necare and services to attain and methe highest level of well-being as in the comprehensive assessment care. R4 received cryotherapy to skin lesions on July 19, 2017. A potate for the lesions has been devand implemented. Visualization, assessments and documentation lesions is done at least weekly. Staff education was completed or 2, 2017.  A policy and procedure for trackin non-pressure skin conditions was reviewed and revised.  Quality assurance and performan improvement audits of non-pressure ongoing completed montlensure ongoing compliance. It will responsibility of the Director of Nudesignee, to ensure these are aucompleted and brought to QAPI in	aintain identified it plan of facial lan of eloped of the n August g of  ce ure skin nly to I be the ursing, or dits are	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(2	(X3) DATE SURVEY COMPLETED	
		245382	B. WING			07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CO 900 SECOND AVENUE MADISON, MN 56256	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 309	heels floated when to educate resident factor and measure Identify/document peliminate /resolve will clean and dry, use pressure redistribut recliner. Weekly skindings and report care plan failed to a lesions, any goals of Review of the follow lacked monitoring of the pressure of the p	in bed or recliner. Staff were /family/caregivers of causative is to prevent skin injury. Sotential causative factors and where possible. Keep skin otion on dry skin, and ion cushion in wheelchair and ion inspections, document to provider as needed. The address R4's chronic facial	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245382	B. WING _		07	/20/2017	
	PROVIDER OR SUPPLIER N HEALTHCARE SEI			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	Physician progress R4 had facial lesio and questioned if tinduced. The physikely a combination Physician progress sore on his right chad been there for indicated R4 tender left cheek sore had slightly. Left lower (centimeter) x 1.0 Right cheek had so over mid right uppowithout ulceration, The physician document likely basal compatient visit with sufficient visit with sufficient possible lesions have been last four years with appointment was and his wife refused Physician progress R4 completed the for possible lesion option. R4 requestlesions daily, and opicking the facial lesions daily, and opicking the facial lesions daily, and opicking the facial lesions daily and opi	s note dated 9/23/16, indicated ns that he tended to pick at, they were chronic or self sician believed it was most n.  Is note dated 1/12/17, R4 had a neek and lower left cheek, and quite some time. The note ed to pick at his sores, and the diprogressed and worsened or cheek measured 1.0 cm cm x 0.5 cm ulcerated area. Caling, mild erythema, edema er cheek. Right lesions is skin breakdown or drainage. Sumented the skins lesions were ell carcinoma, and would have argery for excision.  Idated 1/20/17, indicated R4 of cancer of his face, discussed th R4 and education was given the areas would likely have The note indicated R4's present for approximately the nout resolution. Follow-up scheduled for 2/3/17, which R4		09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		245382	B. WING _		07	//20/2017	
	PROVIDER OR SUPPLIER N HEALTHCARE SER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256		,=,,=,,=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	R4 was to continue cream to the lesion surgery and was re removed but R4 de any type of interver hydrocortisone 1% times per day.  Physician progress R4 was able to see facial lesion, but de Indicated he does at this time. Contin 1% cream to affect On 7/17/17, at 4:58 an open area on hit he area was shiny There were other rewhich were intact. face and stated the stated the spots coon 7/19/17, at 7:17 wheelchair in the disores on his face, right cheek, and or his nose. R4 also areas of redness in On 7/19/17, at 7:42 open areas on his informed R4 he has for the doctor to low Physician progress.	a note dated 5/5/17, indicated a using the Hydrocortisone 1% as on his face. R4 was seen by ecommended to have them eclined and continues to defernation. Continue to use cream to affected areas two a note dated 6/29/17, indicated a surgery about his left sided aftered all options given to him. In the want anything further done have to use the hydrocortisone areas twice per day.  By p.m. R4 was observed with a left cheek next to his nose, and weeping clear fluid. The ed areas around R4's nose areas around R4's nose and weeping clear fluid. The ed areas around R4's nose areas around the areas on his ey did not bother him, and the and go.  To a.m. R4 was observed in a ining room, and had multiple one open area on the left side of was observed to have multiple in these areas.  Definition and the face, clinical manager (CM)-A d an appointment at 9:00 a.m.	F 30	9			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG			E SURVEY IPLETED
		245382	B. WING			07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, 900 SECOND AVENUE MADISON, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROP EFICIENCY)	BE	(X5) COMPLETION DATE
F 309	his facial lesions, an observation, cryothwith freezing. R4 eperformed. R4 has carcinoma, suspect that diagnosis howe performed. Two free performed on each the procedure well return to the clinic acontinued treatment.  On 7/19/17, at 2:00 nursing (ADON) depressure ulcer skindated 7/19/17. The hydrocortisone order effective 7/19/17right cheek, 1.0 x covered with bandatop of nose, 1.4 cm left cheek, red are 0.7 cm x 1.5 cm left corner of nose (mm) depth left of nose, flat an On 7/19/17, at 7:43 agreed to go to the have the facial lesion their own, stated sores healed because frequently and need areas. CM-A denier R4 would pick them.	and discussed options including erapy, excision, and excision lected to have cryotherapy a history of basal cell telesions are consistent with ever, no biopsy had been lesion in which R4 tolerated and it was recommended R4 again in eight weeks for t.  p.m. the assistant director of livered completed noncondition assessments for R4 ADON reported the er had been discontinued  1.6 centimeter (cm)-open area, and after cryotherapy, in x 2.4 cm, flat red a 2.0 cm 5.0 cm, open area  7.0 x 4.0 with a 2.0 millimeter d red, 2.0 x 1.7  a.m. CM-A reported R4 finally doctor for cryotherapy, to ons removed. CM-A stated R4 esions before and have healed it depended how fast the use R4 would touch them d reminders to not touch the d the sores bleeding unless	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245382	B. WING			07/:	20/2017	
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		900	REET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE DISON, MN 56256	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	has had the lesions time.  On 7/19/17, at 7:44 around his face who present. R4 stated he did agree it was R4 indicated the so face for quite some 7/17/17, at 4:58 p.n. areas on his face of there now for a long.  On 7/19/17, at 11:4 (LPN)-B confirmed worked with R4 free a picker, and had a lesions alone. LPN the facial lesions, the facial lesions, the facial lesions, the facial lesions alone is the facial lesions at the facial lesions at the facial lesions, the facial lesions at the facial lesions, the facial lesions at the facial lesions at the facial lesions, the facial lesions at the facial lesions at the facial lesions at the facial lesions, the facial lesions at the facial lesions, the facial lesions at the facial lesions at the facial lesions, the facial lesions at the facial	a.m. R4 denied any pain in or ere the facial lesions were the sores did not bother him, hard for him to not pick them. res had been present on his time. When interviewed on n. R4 and his wife reported the ame and went, and have been g time.  8 a.m. licensed practical nurse she was R4's nurse today and quently. LPN-B stated R4 was hard time leaving the facial -B could not confirm size of the description, the progression and the lesions had been the LPN-B verified staff never non-pressure ulcer skin in would have tracked the ment of each area. LPN-B me and go, then stated the LPN-B reported R4 had been the back and R4 and family the sores, then stated R4 did not today for cyrotherapy, and the up in 8 weeks. LPN-B stated not been treating the sores or medications. When the	F3	09				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245382	B. WING _			07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP 900 SECOND AVENUE MADISON, MN 56256	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD IE APPROPF	BE	(X5) COMPLETION DATE
F 309	written order for the never transcribed a administration recopharmacy, and veriwas filled only one refilled after that. L would have gotten litchy if he would have gotten litchy at 11:5 never implemented facial lesions, and sheets now. CM-A when a resident ha healing. CM-A verif documentation from general weekly skir any specific informal lesions. CM-A verif documentation, stathe progression of the progression. CM-A lacked any documentation. CM-A lacked any documentation, cM-A lacked any documentation.	tly. LPN-B confirmed the hydrocortisone cream was and reflected on the medication rd. LPN-B called the fied the hydrocortisone cream time on 3/10/17, was never PN-B stated maybe the sores better and would not be so we continued to use the firmed it was the facility's ill out a wound skin sheet for uch as a skin tear, open area staff can track the progression of p.m. CM-A confirmed staff the monitoring tool for R4's stated i will start the wound stated staff usually start one is an open area to monitor for fied there was no in the facility other than the innote, which did not include ation regarding R4's facial fied due to the lack of the multiple areas on R4's of aware of R4's prescribed for on 3/9/17 and stated the CM-A confirmed staff had not be use or lack of use of the also verified R4's care plan anting regarding the chronic nic picking, goals or a stated the care plan failed to	F 30	09			

PRINTED: 08/16/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245382	B. WING			07/:	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	EVICES		90	TREET ADDRESS, CITY, STATE, ZIP CODE DO SECOND AVENUE IADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	concerns, and report monitoring R4's fact symptoms of infection measuring the oper documented them a were chronic and waddition, the DON smonitor the usage of which he had been The DON also report skin concerns and to have been identificated he was at his co-morbidities with well.	pressure related skin pred staff should have been sial skin lesions for signs and sions and should have been a areas as they opened and as they healed, as these areas would come and go. In stated she expected staff to sof the hydrocortisone cream prescribed to use in his room. For the state of the would expect these the resident's chronic picking fied on his care plan, and sigh risk given his his anticoagulation use as	F3	609			
F 441 SS=F	form procedure pol would fill out the for was not a pressure wound, or neuropal indicated the form vidiscovery of skin conversed the skin area ulcer skin condition resident medical re 483.80(a)(1)(2)(4)(e) PREVENT SPREAR (a) Infection preventant medical re and control programa minimum, the followed the form of the facility must estand control programa minimum, the followed the form of the facility must estand control programa minimum, the followed the form of the facility must estand control programa minimum, the followed the form of the facility must estand the followed the form of the facility must estand the followed the form of the facility must estand the followed the	e)(f) INFECTION CONTROL, D, LINENS ation and control program. stablish an infection prevention on (IPCP) that must include, at	F 4	141			8/29/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(		SURVEY PLETED
		245382	B. WING			07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, 2 900 SECOND AVENUE MADISON, MN 56256	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD E THE APPROPR	3E	(X5) COMPLETION DATE
F 441	communicable dise volunteers, visitors, providing services to arrangement based conducted accordinaccepted national simplementation is F  (2) Written standard for the program, whimited to:  (i) A system of surv possible communic before they can sprifacility;  (ii) When and to who communicable disereported;  (iii) Standard and trobe followed to provide for the program in the involved, and (B) A requirement to least restrictive poscircumstances.  (v) The circumstant must prohibit employed.	ontrolling infections and ases for all residents, staff, and other individuals under a contractual upon the facility assessment of the standards (facility assessment chase 2);  ds, policies, and procedures inch must include, but are not eillance designed to identify able diseases or infections ead to other persons in the som possible incidents of ase or infections should be ansmission-based precautions event spread of infections; isolation should be used for a		41			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		245382	B. WING		07/20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SEF	VICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 441	(vi) The hand hygie by staff involved in  (4) A system for recunder the facility's actions taken by th  (e) Linens. Person process, and transpersed of infection.  (f) Annual review. annual review of its program, as necess. This REQUIREMED by:  Based on observative review, the facility finfection control memaintained while steat foods in 1 of 2. If Findings include:  During dining obsepm. the refrigerato One was noted to have packs located on the freezer. Two blue restricted in the top shelf a first strawberry swirl and eat individual ice or shelf. One blue restort of the freezer paper bag containing the strawber of the strawber of the freezer paper bag containing the strawber of the strawber of the freezer paper bag containing the strawber of the st	the disease; and  the disease; and  the procedures to be followed direct resident contact.  cording incidents identified PCP and the corrective efacility.  The facility will conduct an appropriate the property oring ice packs with ready to	F 44	An infection prevention and control program has been established. A post and procedure for storage of resider items including ice packs has been developed. The noted ice packs were immediately put into storage bags at time this problem was identified on 17, 2017. The facility no longer uses re-usable ice packs and instead will disposable packs.  Staff education was completed on A 2, 2017.  Quality assurance audits of facility refrigerators and freezers will be completed at least monthly to ensure ongoing compliance. The Director on Nursing, or designee, will be respons for ensuring these audits are completed and brought to QAPI meeting.	et care the the July the use ugust effsible

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245382	B. WING		07/	20/2017
	PROVIDER OR SUPPLIER N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	(LPN)-A visualized confirmed the above the re-usable ice particles body when a reside orders for ice packs falls or lower back pathey used a towel of when they used the indicated she clean sanitization wipes.  On 7/17/2017, at 5 (DON) visualized an findings. DON indicated to not store ice pactitems. DON verified foods should not be control management unaware that they say container if stored was facility did not have storage.	e freezer.  It p.m. licensed practical nurse the Station One freezer and the findings. LPN-A confirmed acks were used on a resident tent in the facility had physician is or as needed for injury from coain. LPN-A also indicated our sleeve to cover the ice packs are on resident. LPN -A tend the ice packs after use with the facility procedure was also in the same shelf as food dice packs and ready to eat the stored together for infection and the indicated she was should be stored in a separate with food. DON indicated the a policy for proper ice pack	F 4	41		
F 465 SS=E	and infection controprovided. 483.90(i)(5)	ty policy on ice pack storage of was requested, but not AL/SANITARY/COMFORTABL	F 4	65		8/29/17
		ovide a safe, functional, ortable environment for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245382	B. WING _		07/:	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 465	applicable Federal, regulations, regardi and smoking safety non-smoking reside This REQUIREMEN by: Based on observat review, the facility fand maintenance s a clean and sanitar and bathrooms for (South 107,113,125, 127, 135) reviewed  Findings include: On 7/19/17, at 12:2 environmental tour director (ED) the foconcerns were observative of the same application of the search part of the searc	is, in accordance with State, and local laws and ing smoking, smoking areas, is that also take into account ents.  NT is not met as evidenced ion, interview and document ailed to provide housekeeping ervices necessary to maintain y condition in resident rooms of 30 resident rooms of,127, West 115, 123, 125,  2 p.m. during the with the environmental llowing environmental erved:  Per portion of the bathroom and gouges out of the sheet broximately two inches in  aroom sink faucets had heavy	F 46	The facility will provide education on the importance of reporting dar walls, faucet corrosion, etc. along process of reporting. This education be completed by August 29, 2017. The policy titled, Preventative Maintenance Program, has been reviewed and revised to change the frequency of preventative mainten audits from quarterly to monthly. The Environmental Services Direct designee, will be responsible for a being completed and brought the Assurance Performance Improver committee. Completed audits will brought to QAPI at least quarterly ensure ongoing compliance.  Room 107: Bathroom wall gouges been patched, sanded and painted Completed July 26, 2017.  Room 113: Sink faucet parts were replaced. Completed July 27, 2017.  Room 125: Sink faucet parts have replaced. Completed August 10, 2 The bathroom door has been sand stained and varnished. Completed August 14, 2017.  The sheet rock around the fan coil be replaced and painted. The fan will be sanded, cleaned and painted. Completed August 29, 2017.	nage to with the on will le ance tor, or udits Quality nent be to have d.  7. been 017. ded, on unit will coil unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245382	B. WING			07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES		9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SECOND AVENUE MADISON, MN 56256		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 465	had scrapes and chrough areas.  Room 127: the floothroughout the room the bed.  West hall:  Room 115: the hot buildup with some of the faucet handle.  Room 123: the wall vertical gouges into through the sheet rewhich measured for floor was sticky near the room.  Room 125: the pair outside wall near the was bubbled and so register was rusted of the unit.  Room 127: the bath paint and sheet root toilet.  Room 135: the bath through the sheet received in the confirming of the confirming and confirming the sheet received in the confirming sheets. Follow maintenance scheet received in the confirming sheets. Follow maintenance scheet received in the confirming sheets. Follow maintenance scheet received in the confirming sheets. Follow maintenance scheets.	r had dark black/gray stains in with darker areas along side water faucet had lime scale water leakage around the base e.  next to the bed had multiple of the sheet rock and a hole ock at the head of the bed fur inches by six inches and the far the bed and to the center of the window and heat register off to the touch. The heat along the left side and bottom had pealing/ bubbling k surrounding the back of the moom wall had two holes ock the diameter of a pencil.  22 p.m. the ED verified the ned the maintenance aware of the aforementioned	F 4	.65	Room 127: The floor was scrubber buffed to repair damages. Completed 31, 2017.  The sheet rock was repaired by particle and painting. Completed July 27, 28, 2017.  Room 115: Sink faucet parts have replaced. Completed July 27, 2017.  Room 123: The hole and gouges rewill be patched and painted. Company August 18, 2017.  Room 135: The two holes were particle and painted. Completed July 26, 2017.	ted July atching 2017. been 7. noted bleted tched	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245382	B. WING		07	/20/2017	
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTHCARE SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE  900 SECOND AVENUE  MADISON, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 465	The ED stated the fidentify and repair fikeeping problems, overlooked the ider becomes common same environment quarterly audit of the for the end of the more that time.  The facility policy tit Program, revised 1 was to provide the fidentification.	facility had a plan in place to acility maintenance and house however, staff may have ntified repair needs as it place when working in the daily. The ED stated a e entire facility was scheduled nonth and he believed these would have been identified at the Preventive Maintenance 1/16, indicated the purpose	F 4	65			

F5382025

Printed: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245382

B. WING

07/19/2017

NAME OF PROVIDER OR SUPPLIER

#### MADISON HEALTHCARE SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE

### 900 SECOND AVENUE MADISON, MN 56256

MADISON HEALTHOAKE SERVICES		MADISON, MN 56256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	II GULATORY PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	K	000				
	FIRE SAFETY						
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Strice Marshal Division, on July 19, 2017. A time of this survey, Madison Healthcare Se Nursing Home was found to be in compliat with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2 edition of National Fire Protection Associat (NFPA) 101, Life Safety Code (LSC), Chap Existing Health Care Occupancies.	tate t the ervices nce 012 tion					
	Madison Healthcare Services Nursing Hor 3-story building with partial basement, and fire sprinkler protected. The original buildi constructed in 1914 and was determined to Type I(322) construction. The 1952 addition determined to be of Type I(332) construction. The 1968 addition was determined to be of II(111) construction. The 1977 addition was determined to be of Type II(111) construction. The 1991 addition was determined to be of II(111) construction. Because the original and the four additions met the construction allowed for existing buildings, the facility was urveyed as one building. The 1914 and obuildings are a "B" Occupancy.	I is fully ng was to be of on was on. If Type as ion. If Type building n types //as					
	The facility has a fire alarm system with sr detection in the corridors and spaces oper corridors, and is monitored fr automatic fir department notification. The facility has a capacity of 65 beds and had a census of 5 time of the survey.	n to the			ā		
	The requirement at 42 CFR, Subpart 483. MET.	70(a) is			(X6) DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TNDA21

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.

Printed: 07/26/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIE	R/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION NU				A. BUILDING 01 - MAIN BUILDING 01					
245382						07/19	07/19/2017		
	ROVIDER OR SUPPLIER				STATE, ZIP CODE				
MADISO	N HEALTHCARE S	ERVICES		900 SECOND AVENUE MADISON, MN 56256					
	T					CTION	(X5)		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 10, 2017

Mr. Justin Hughes, Administrator Madison Healthcare Services 900 Second Avenue Madison, MN 56256

Re: State Nursing Home Licensing Orders - Project Number S5382026

Dear Mr. Hughes:

The above facility was surveyed on July 17, 2017 through July 20, 2017 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 Gail Anderson at (218) 332-5140 or email: mark.meath@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: \_\_\_

00329

IDENTIFICATION NUMBER:

B. WING

07/20/2017

		00329		B. WING		07/20/201	7
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES		OND AVENUE I, MN 56256			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		CIENCIES EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMF	(5) PLETE ATE
2 000	Initial Comments			2 000			
	****ATTEN	NTION*****					
	NH LICENSING	CORRECTIO	N ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Ruwhen a rule contain comply with any of tack of compliance. re-inspection with a result in the assess that was violated ducorrected.	ction order has y. If, upon rei iency or deficiency or def	s been issued nspection, it is encies cited or each violation n accordance ated by rule of alth.  ion has been th all at the tag licated below. ns, failure to be considered pliance upon lti-part rule will even if the item				
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-complia t a written req nin 15 days of	nce with these uest is made to receipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the at	participate in nsure orders of artment of Hea in 14-01, avail tate.mn.us/div e licensing ord	consistent with alth lable at s/fpc/profinfo/inf ders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

08/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00329	B. WING		07/2	20/2017
	PROVIDER OR SUPPLIER N HEALTHCARE SER	VICES 900 SEC	DRESS, CITY, S DND AVENUE N, MN 56256	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	you electronically, is necessary for State enter the word "corn text. You must then State licensure procompletion date, the corrected prior to electronic plan of corners are issued, electronic plan of corneviewed these ord they will be completed they will be completed. Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned the Minnesota Department the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of compare the statement evidence by." Followare the Suggested Time period for Control of the Statement of the Statement of the Suggested Time period for Control of the Statement of the Statement of the Suggested Time period for Control of the Statement of the Statemen	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  7/18/17, 7/19/17, and 7/20/17, epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date when ted.  Then of Health is documenting correction Orders using an umbers have been nota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and rection.	2 000			
	FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS				

6899

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00329	B. WING	B. WING		20/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	_	
MADISO	N HEALTHCARE SER	VICES	ND AVENUE I, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			9/1/17
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The comust include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review, the facility fa which identified chr	ent is not met as evidenced on, interview and document ailed to develop a care plan onic facial lesions for 1 of 3 ewed for non-pressure related		Corrected		
	Findings include:					
	6/2/17, revealed R4 hemiplegia, depress of anticoagulants (b had moderate impa required extensive	m Data Set (MDS) dated had diagnoses which include sion, aphasia, long-term use blood thinning medication), and irred cognition. The resident assist of one person with ng including bed mobility, illeting.				

Minnesota Department of Health

STATE FORM 6899 TNDA11 If continuation sheet 3 of 21

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES	ND AVENUE I, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 560	R4's care plan revisithe potential for implinterventions includ hands and body parkeep fingernails shoompliant, keep herecliner. Educate recausative factor and injury. Identify/doct factors and eliminative factors and report care plan did not administer plan did not administer follow up whossible removal. It used hydrocortisonare duce him picking note identified R4's self-administered the R4's current physicid directed the administer factors. Physician progress R4 had facial lesionand questioned if the induced. The physician progress R4 had facial physician progress R4 had facial progress R4 had facial physician progress Physician Phy	sed 7/24/14, identified "I have bairment to skin integrity. ed, avoid scratching and keep outs from excessive moisture. Fort. Booties to heels, when els floated when in bed or esident/family/caregivers of dimeasures to prevent skin ament potential causative to /resolve where possible. It dry. Use lotion on dry skin. It is in cushion in wheelchair and it in inspections, document to provider as needed. The ladress facial lesions and some of the decrease itching and and scratching areas. The skin at risk and indicated R4 to decrease itching and and scratching areas. The skin at risk and indicated R4 to hydrocortisone cream.  If an orders signed 6/29/17, stration of hydrocortisone 1% or et imes per day) to facial y have in his room.  In ote dated 9/23/16, indicated its that he tended to pick at, ney were chronic or selfician believed it was most	2 560			
		quite some time. The note				

Minnesota Department of Health

STATE FORM 6899 TNDA11 If continuation sheet 4 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00329	B. WING		07/2	0/2017
	PROVIDER OR SUPPLIER	VICES 900 SECO	DRESS, CITY, S DND AVENUE I, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 560	indicated R4 tended left cheek sore had slightly. Left lower (centimeter) x 1.0 c Right cheek had so over mid right uppe without ulceration, s The physician docu most likely basal cepatient visit with sur Consultation visit dalikely had 3 areas o surgical options with with no treatment the slow progression. I lesions have been plast four years with appointment was so and his wife refused Physician progress R4 completed the compossible lesion option. R4 request lesions daily, and copicking the facial lecream to be applied lesions was ordered he may have that more physician progress R4 was to continue cream to the lesions surgery and was regremoved but R4 de any type of intervention.	d to pick at his sores, and the progressed and worsened cheek measured 1.0 cm cm x 0.5 cm ulcerated area. aling, mild erythema, edema r cheek. Right lesions is skin breakdown or drainage. Imented the skins lesions were call carcinoma, and would have regery for excision.  ated 1/20/17, indicated R4 of cancer of his face, discussed h R4 and education was given the areas would likely have the note indicated R4's present for approximately the put resolution. Follow-up cheduled for 2/3/17, which R4				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00329	B. WING	<del></del>	07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES 900 SEC	DDRESS, CITY, S DND AVENUE N, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Physician progress R4 was able to see facial lesion, but de Indicated he does nat this time. Contin 1% cream to affecte Physician progress R4 was seen by the his facial lesions, at observation, cryothe with freezing. R4 eperformed. R4 has carcinoma, suspect that diagnosis: how performed. 2 freezon each lesion, R4 and recommended weeks for continue On 7/17/17, at 4:58 an open area on his the area was shiny. There were other rewhich we intact. R4 face and stated the reported the spots of the continue on 7/19/17, at 7:17 wheelchair in the disores on his face, or right cheek, and on his nose. R4 also wareas of redness in On 7/19/17, at 7:42 open areas on his f	note dated 6/29/17, indicated surgery about his left sided ferred all options given to him. not want anything further done ue to use the hydrocortisone ed areas twice per day.  note dated 7/19/17, indicated a general surgeon in regards to and discussed options including erapy, excision, and excision lected to have cryotherapy a history of basal cell a lesions are consistent with ever, no biopsy has been e thaw cycles were performed tolerated the procedure well, to return to the clinic again 8 d treatment.  p.m. R4 was observed with a left cheek next to his nose, and weeping clear liquid. The dareas around R4's nose at touched the areas on his y did not bother him, and come and go.  a.m. R4 was observed in a ning room, and had multiple one open area on the left side of was observed to have multiple these areas.  a.m. R4 was pointing to the ace, clinical manager (CM)-A dan appointment at 9:00 a.m.				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00329	B. WING		07/2	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES 900 SECO	DRESS, CITY, S DND AVENUE I, MN 56256	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	On 7/19/17, at 2:00 nursing (ADON) de pressure ulcer skin dated 7/19/17. The hydrocortisone orde effective 7/19/17right cheek, 1.0 x with bandaids after -top of nose, 1.4 cm -left cheek, red are 0.7 cm x 1.5 cm -left corner of nose -left of nose, flat an On 7/19/17, at 2:19 stated R4 picked hi has had the lesions time.  On 7/19/17, at 7:44 around his face who present. R4 stated he did agree it was R4 indicated the so face for quite some 7/17/17, at 4:58 p.m.	p.m. the assistant director of livered a completed noncondition assessments for R4 ADON reported the er had been discontinued.  1.6 cm-open area, covered cryotherapy, n x 2.4 cm, flat red a 2.0 cm 5.0 cm, open area.  7.0 x 4.0 with a 2.0 mm depth d red, 2.0 x 1.7  p.m. nursing assistant (NA)-As face a lot, and confirmed heron his face for quite some.  a.m. R4 denied any pain in or ere the facial lesions were the sores did not bother him, hard for him to not pick them. res had been present on his time. When interviewed on not R4 and his wife reported the ome and go, and have been	2 560			
	(LPN)-B confirmed worked with R4 fred a picker, and had a lesions alone. LPN the facial lesions, the of healing or how low present on R4's factories and go, then LPN-B reported R4	8 a.m. licensed practical nurse she was R4's nurse today and quently. LPN-B stated R4 was hard time leaving the facial -B could not confirm size of ne description, the progressioning the lesions had been e. LPN-B stated the sores stated the sores were cancer. had been to the doctor a and family decided not to treat				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00329	B. WING		07/2	0/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES	ND AVENUI I, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	plan lacked any doc chronic facial lesion interventions, CM-A identity this concern 07/20/17, at 11:42 (DON) confirmed sl concerns and the re have been identified	O p.m. CM-A verified R4's care cumentation regarding the as, chronic picking, goals or a stated the care plan failed to a all together.  a.m. the director of nursing the would expect these skin esident's chronic picking to d on his care plan, and stated given his co-morbidities with				
	indicated all resider	lan policy dated 5/2017, nt would have a plan of care, wed and revised at least eded based on				
	The director of nursidevelop and implementated to the develorate plans. The DC training for all nursidevelopment of contracts	CHOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures opment of comprehensive N or designee, could provide ng staff related to the nprehensive care plans. The and assurance committee om audits to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			9/1/17

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00329	B. WING		07/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES	ND AVENUE , MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Subpart 1. Care in receive nursing carcustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain prefers to remain in This MN Requirements.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.	2 830			
	review, the facility fareoccurring facial standard (R4) reviewed for national conditions.  Findings include:  A quarterly Minimur 6/2/17, revealed R4 hemiplegia, depress of anticoagulants (bhad moderate imparequired extensive Activity of Daily Livitransferring, and to Care conference not R4 continued to have declined follow up to possible removal. I used hydrocortisons	on, interview and document ailed to identify and monitor kin lesions for 1 of 1 resident on pressure related skin  In Data Set (MDS) dated had diagnoses which include sion, aphasia, long-term use plood thinning medication), and ired cognition. The resident assist of one person with assist of one person withing including bed mobility, leting.  In dated 5/31/17, indicated we cancer lesions on face, with surgeon to discuss further, the note indicated R4 et o decrease itching and and scratching areas. The		Corrected		

Minnesota Department of Health

STATE FORM 6899 TNDA11 If continuation sheet 9 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/	20/2017
	PROVIDER OR SUPPLIER  N HEALTHCARE SER	VICES 900	SECOND AVENUI DISON, MN 56256	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	note identified R4's self-administered the R4's current physic directed the adminicream. apply tid (the lesions. Patient material R4's care plan revisions the potential for implication indications are plan for implications. Patient material for implication indications indicated when to educate resident factor and measure identify/document peliminate /resolve with clean and dry, use pressure redistributing recliner. Weekly shindings and report care plan failed to a lesions, any goals of Review of the follow lacked monitoring of the pressure identification in the pressure used in the pressure	skin at risk and indicated he hydrocortisone cream. It is an orders signed 6/29/17 stration of hydrocortisone ree times per day) to facing have in his room.  Seed 7/24/14, indicated R4 pairment to skin integrity. It is ted R4 was to avoid keep hands and body part is ture, keep fingernails shapen compliant, and to kee in bed or recliner. Staff well family/caregivers of caus is to prevent skin injury. It is to prevent skin injury. It is to prevent skin injury. It is to prevent skin, and it is to provider as needed. The ddress R4's chronic facing its provider as needed. The ddress R4's chronic facing its provider as needed.	had had sort, prere ative and and and and set			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00329	0329 B. WING		07/20/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	RVICES	OND AVENUE I, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	-R4's care plan targ-Weekly visual skin to 7/16/17, were ret 1/8/17, indicated ar area cleansed, lotic 3/12/17, indicated for were stable, under physician, no new a notes indicated a vihad been complete concern. No meas documented on the Physician progress R4 had facial lesion and questioned if the induced. The physician progress sore on his right cheal been there for indicated R4 tender left cheek sore had slightly. Left lower (centimeter) x 1.0 c Right cheek had so over mid right upper without ulceration, so the physician documost likely basal consultation visit dikely had 3 areas of surgical options with with no treatment the slow progression. I lesions have been placed to the surgical options with some progression.	geted date of 8/28/17 inspection notes from 9/1/16, viewed. One note dated open area noted to face, on applied. One note dated at had lesions of face and treatment ordered by the area of concern. All other sual inspection of R4's skind with no new areas of urements or description was a 1/8/17, or 3/12/17, note.  Inote dated 9/23/16, indicated as that he tended to pick at, ney were chronic or selfician believed it was most and the progressed and worsened do pick at his sores, and the progressed and worsened cheek measured 1.0 cm cm x 0.5 cm ulcerated area. It is aling, mild erythema, edema or cheek. Right lesions is skin breakdown or drainage. Imented the skins lesions were all carcinoma, and would have				

Minnesota Department of Health

STATE FORM 6899 TNDA11 If continuation sheet 11 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/	20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES 900 SEC	OND AVENUE	<u> </u>		
WIADISO	N HEALTHCARE SER	MADISOI	N, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Physician progress R4 completed the of for possible lesion roption. R4 requestresions daily, and opicking the facial lecream to be applied lesions was ordered he may have that more applied lesions was ordered he may have that more applied lesions was ordered he may have that more applied lesions was ordered he may have that more applied lesions was represented but R4 deany type of interventy hydrocortisone 1% times per day.  Physician progress R4 was able to see facial lesion, but de Indicated he does rat this time. Continuty or 1% cream to affected on 7/17/17, at 4:58	cheduled for 2/3/17, which R4 d to attend.  note dated 3/9/17, indicated consultation visit with surgery removed, and deferred that ed a cream to use on his facial ontinued with anxiety and sions. Hydrocortisone 1% d three times daily to facial d. R4 was given the order that nedication in his room.  note dated 5/5/17, indicated using the Hydrocortisone 1% s on his face. R4 was seen by commended to have them clined and continues to defer ation. Continue to use cream to affected areas two  note dated 6/29/17, indicated surgery about his left sided ferred all options given to him. Not want anything further done use to use the hydrocortisone ed areas twice per day.  p.m. R4 was observed with				
	an open area on his the area was shiny There were other re which were intact. face and stated the stated the spots con	s left cheek next to his nose, and weeping clear fluid. ed areas around R4's nose R4 touched the areas on his y did not bother him, and me and go.				
	wheelchair in the di	a.m. R4 was observed in a ning room, and had multiple one open area on his left and				

Minnesota Department of Health

STATE FORM 6899 TNDA11 If continuation sheet 12 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			P WING			
		00329	B. WING		07/2	0/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	RVICES	OND AVENUE ON, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 12	2 830			
	right cheek, and on	ue open area on the left side owas observed to have multiple				
	On 7/19/17, at 7:42 a.m. R4 was pointing to the open areas on his face, clinical manager (CM)-A informed R4 he had an appointment at 9:00 a.m. for the doctor to look at his sores.					
	Physician progress note dated 7/19/17, indicated R4 was seen by the general surgeon in regards to his facial lesions, and discussed options including observation, cryotherapy, excision, and excision with freezing. R4 elected to have cryotherapy performed. R4 has a history of basal cell carcinoma, suspect lesions are consistent with that diagnosis however, no biopsy had been performed. Two freeze thaw cycles were performed on each lesion in which R4 tolerated the procedure well and it was recommended R4 return to the clinic again in eight weeks for continued treatment.		О			
	nursing (ADON) de pressure ulcer skin dated 7/19/17. The hydrocortisone orde effective 7/19/17right cheek, 1.0 x covered with banda -top of nose, 1.4 cm -left cheek, red are 0.7 cm x 1.5 cm	a 2.0 cm 5.0 cm, open area 7.0 x 4.0 with a 2.0 millimete	4 a,			
		a.m. CM-A reported R4 finall doctor for cryotherapy, to	У			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
MADISO	MADISON HEALTHCARE SERVICES  900 SECO MADISON					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	have the facial lesich has had the facial lesich on their own, stated sores healed because frequently and need areas. CM-A denier R4 would pick them.  On 7/19/17, at 2:19 stated R4 picked his had the lesionstime.  On 7/19/17, at 7:44 around his face whe present. R4 stated he did agree it was R4 indicated the soface for quite some 7/17/17, at 4:58 p.n. areas on his face of there now for a long.  On 7/19/17, at 11:4 (LPN)-B confirmed worked with R4 fred a picker, and had a lesions alone. LPN the facial lesions, the facial lesions, the facial lesions, the facial lesions, the facial lesions the green on R4's face started the weekly is condition tool which progress and treatment stated the sores consores were cancer. To the doctor a while decided not to treat have an appointment.	ons removed. CM-A stated R4 esions before and have healed it depended how fast the use R4 would touch them dereminders to not touch the detended the sores bleeding unless in.  p.m. nursing assistant (NA)-A seface a lot, and confirmed healer on his face for quite some  a.m. R4 denied any pain in or ere the facial lesions were the sores did not bother him, hard for him to not pick them. It is not present on his time. When interviewed on in. R4 and his wife reported the ame and went, and have been	2 830	DETIGIENCT)		

Minnesota Department of Health

winnesc	ita Department of He	aim				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00329		B. WING		07/20/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	900 SECO			<u> </u>		
MADISO	N HEALTHCARE SER	WADISON MADISON	N, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	confirmed staff had not been treating the sores with any treatments or medications. When the surveyor questioned LPN-B about the hydrocortisone order written on 3/9/17 by R4's physician,she was not aware of that, and stated she had never used it, and confirmed she had never seen the resident use it. LPN-B reported R4 used A and D ointment in the past, but never the hydrocortisone cream, and stated we are there quite frequently. LPN-B confirmed the written order for the hydrocortisone cream was never transcribed and reflected on the medication administration record. LPN-B called the pharmacy, and verified the hydrocortisone cream was filled only one time on 3/10/17, was never refilled after that. LPN-B stated maybe the sores would have gotten better and would not be so itchy if he would have continued to use the cream. LPN-B confirmed it was the facility's normal practice to fill out a wound skin sheet for any skin concern, such as a skin tear, open area or bruise to ensure staff can track the progression of healing.					
	never implemented facial lesions, and s sheets now. CM-A when a resident ha healing. CM-A veri					
	general weekly skir any specific informal lesions. CM-A verif documentation, stathe progression of the face. CM-A was not hydrocortisone order	In the facility other than the note, which did not include ation regarding R4's facial fied due to the lack of ff were unable to determine the multiple areas on R4's of aware of R4's prescribed er on 3/9/17 and stated the CM-A confirmed staff had not				

Minnesota Department of Health

been monitoring the use or lack of use of the

STATE FORM 6899 If continuation sheet 15 of 21 TNDA11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00329	B. WING		07/2	20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MADISO	N HEALTHCARE SER	RVICES	OND AVENUE N, MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	medication. CM-A lacked any docume facial lesions, chror interventions, CM-A identity this concern 07/20/17, at 11:42 (DON) verified she and monitor all non concerns, and report monitoring R4's fact symptoms of infection measuring the oper documented them awere chronic and ware been identificated he was at his co-morbidities with well.  The facility's non-proportion form procedure polywould fill out the form was not a pressure wound, or neuropation indicated the form was not a pressure wound.	also verified R4's care plan enting regarding the chronic nic picking, goals or a stated the care plan failed to a all together.  a.m. the director of nursing expected staff to document pressure related skin orted staff should have been fial skin lesions for signs and ions and should have been areas as they opened and as they healed, as these areas would come and go. In stated she expected staff to find the hydrocortisone cream prescribed to use in his room. Orted she would expect these the resident's chronic picking fied on his care plan, and figh risk given his his anticoagulation use as a ressure ulcer skin conditions icy dated 2007, indicated staff on any skin concern that ulcer, arterial wound, venous thy/diabetic wound. The policy would be filled out upon condition and then at least only one skin condition per for. I was healed, the non-pressure form was to be filed into the cord.				
		THOD OF CORRECTION: sing could develop policies and	1			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00329	B. WING	····	07/2	20/2017
	NAME OF PROVIDER OR SUPPLIER  MADISON HEALTHCARE SERVICES  MADISO  MADISO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	procedures related care for non pressu and monitoring, edu polices, and audit ru to these policies an	to development of plan of are ulcer skin assessments ucate staff regarding these esident records for compliance	2 830			
21375	Program  Subpart 1. Infection home must establish	on Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and ont.	21375			9/1/17
	by: Based on observatireview, the facility fainfection control me	ent is not met as evidenced on, interview and document ailed to ensure appropriate easures were properly oring ice packs with ready to kitchenettes.		Corrected		
	p.m. the refrigerato One was noted to h packs located on the freezer. Two blue re- on the top shelf a fe strawberry swirl and eat individual ice cr shelf. One blue re- bottom of the freeze	rvation on 7/17/17, at 5:21 r in the kitchenette on Station have three blue re-usable ice top shelf and bottom of the e-usable ice packs were laying the winches away from fourteen districted six chocolate swirl ready to eam cups on the top freezer usable ice pack was on the ter, partially lying on a browning six Dairy Queen dilly bars.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N HEALTHCARE SER	VICES	ND AVENUE , MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 17	21375			
	on the bottom of the					
	(LPN)-A visualized confirmed the above the re-usable ice parabody when a reside orders for ice packs falls or lower back pathey used a towel of when they used the	p.m. licensed practical nurse the Station One freezer and e findings. LPN-A confirmed acks were used on a resident ent in the facility had physician s or as needed for injury from pain. LPN-A also indicated r sleeve to cover the ice packs em on resident. LPN -A ed the ice packs after use with				
	On 7/17/2017, at 5:28 p.m. director of nursing (DON) visualized and confirmed the above findings. DON indicated the facility procedure was to not store ice packs on the same shelf as food items. DON verified ice packs and ready to eat foods should not be stored together for infection control management, but indicated she was unaware that they should be stored in a separate container if stored with food. DON indicated the facility did not have a policy for proper ice pack storage.					
	On 7/17/17, a facility policy on ice pack storage and infection control was requested, but not provided.					
	The director of nursidevelop and implementated to infection cross contamination provide training for quality assessment	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures control and prevention of n with ice pack storage, all nursing staff, and the and assurance committee om audits to ensure				

6899

_	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00329	B. WING	<del></del>	07/2	0/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MADISO	N HEALTHCARE SER	VICES	ND AVENUE I, MN 56256				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 18	21375				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21665	MN Rule 4658.1400	) Physical Environment	21665			9/1/17	
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.					
	by: Based on observati review, the facility fa and maintenance sa a clean and sanitary and bathrooms for	ent is not met as evidenced on, interview and document ailed to provide housekeeping ervices necessary to maintain y condition in resident rooms 9 of 30 resident rooms 25, 127, West 115, 123, 125,		Corrected			
	Findings include:						
		with the environmental llowing environmental					
	South hall:						
	wall had multiple ro	er portion of the bathroom und gouges out of the sheet proximately two inches in					
	Room 113: the bath build up of lime sca	room sink faucets had heavy le.					

6899

		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00329	B. WING		07/	20/2017
MADISON HEALTHCARE SERVICES  900 SECO MADISON		OND AVENUE	E		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Room 125: the bath leaked/trickled water stopped resulting in buildup around the amount of lime scal hot water faucet. Thad scrapes and chrough areas.  Room 127: the floor throughout the room the bed.  West hall:  Room 115: the hot buildup with some wof the faucet handle.  Room 123: the wall vertical gouges into through the sheet rowhich measured for floor was sticky near the room.  Room 125: the pair outside wall near the was bubbled and so register was rusted of the unit.  Room 127: the bath paint and sheet roc toilet.	proom sink cold water faucet er which was unable to be a large amount of lime scale base of the faucet and a small le was around the base of the The edge of the bathroom doornips in the wood which caused ar had dark black/gray stains in with darker areas along side water leakage around the base e.  In next to the bed had multiple to the sheet rock and a hole ock at the head of the bed ur inches by six inches and the ar the bed and to the center of the window and heat register of to the touch. The heat along the left side and bottom had pealing/ bubbling k surrounding the back of the heroom wall had two holes				
	·				
	PROVIDER OR SUPPLIER  N HEALTHCARE SER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa  Room 125: the bath leaked/trickled wate stopped resulting in buildup around the amount of lime sca hot water faucet. had scrapes and ch rough areas.  Room 127: the floo throughout the roor the bed.  West hall:  Room 115: the hot buildup with some v of the faucet handl Room 123: the wall vertical gouges into through the sheet re which measured fo floor was sticky nea the room.  Room 125: the pair outside wall near th was bubbled and so register was rusted of the unit.  Room 127: the bath paint and sheet roc toilet.  Room 135: the bath through the sheet re th	PROVIDER OR SUPPLIER  N HEALTHCARE SERVICES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  Room 125: the bathroom sink cold water faucet leaked/trickled water which was unable to be stopped resulting in a large amount of lime scale buildup around the base of the faucet and a small amount of lime scale was around the base of the hot water faucet. The edge of the bathroom door had scrapes and chips in the wood which caused rough areas.  Room 127: the floor had dark black/gray stains throughout the room with darker areas along side the bed.  West hall:  Room 115: the hot water faucet had lime scale buildup with some water leakage around the base of the faucet handle.  Room 123: the wall next to the bed had multiple vertical gouges into the sheet rock and a hole through the sheet rock at the head of the bed which measured four inches by six inches and the floor was sticky near the bed and to the center of the room.  Room 125: the paint and sheet rock on the outside wall near the window and heat register was bubbled and soft to the touch. The heat register was rusted along the left side and bottom of the unit.  Room 127: the bathroom had pealing/ bubbling paint and sheet rock surrounding the back of the	OF CORRECTION  O0329  STREET ADDRESS, CITY, SOON SECOND AVENUM MADISON, MN 56256  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  Room 125: the bathroom sink cold water faucet leaked/frickled water which was unable to be stopped resulting in a large amount of lime scale buildup around the base of the faucet and a small amount of lime scale was around the base of the hot water faucet. The edge of the bathroom door had scrapes and chips in the wood which caused rough areas.  Room 127: the floor had dark black/gray stains throughout the room with darker areas along side the bed.  West hall:  Room 115: the hot water faucet had lime scale buildup with some water leakage around the base of the faucet handle.  Room 123: the wall next to the bed had multiple vertical gouges into the sheet rock and a hole through the sheet rock at the head of the bed which measured four inches by six inches and the floor was sticky near the bed and to the center of the room.  Room 125: the paint and sheet rock on the outside wall near the window and heat register was bubbled and soft to the touch. The heat register was rusted along the left side and bottom of the unit.  Room 127: the bathroom had pealing/ bubbling paint and sheet rock surrounding the back of the toilet.  Room 135: the bathroom wall had two holes through the sheet rock the diameter of a pencil.	OF CORRECTION    DENTIFICATION NUMBER:   A BUILDING:   B. WING   B	OF CORRECTION  OB329  B. WING  DENTIFICATION NUMBER:  DO329  B. WING  DO77  B. WING  DO77  B. WING  DO77  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  900 SECOND AVENUE  MADISON, MN 56256  SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MIST'S BE PRECEDED BY FULL REGULATORY ON LSC DENTIFYING INFORMATION)  PREFIX TAG  COntinued From page 19  21665  Continued From page 19  21665  Room 125: the bathroom sink cold water faucet leaked/trickled water which was unable to be stopped resulting in a large amount of lime scale buildup around the base of the faucet and a small amount of lime scale was around the base of the faucet and a small amount of lime scale was around the base of the hot water faucet. The edge of the bathroom door had scrapes and chips in the wood which caused rough areas.  Room 127: the floor had dark black/gray stains throughout the room with darker areas along side the bed.  West hall:  Room 115: the hot water faucet had lime scale buildup with some water leakage around the base of the faucet handle.  Room 123: the wall next to the bed had multiple vertical gouges into the sheet rock and a hole through the sheet rock at the head of the bed which measured four inches by six inches and the floor was sticky near the bed and to the center of the room.  Room 125: the paint and sheet rock on the outside wall near the window and heat register was bubbled and soft to the touch. The heat register was rusted along the left side and bottom of the unit.  Room 127: the bathroom had pealing/ bubbling paint and sheet rock surrounding the back of the toilet.  Room 135: the bathroom wall had two holes through the sheet rock the diameter of a pencil.

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00329	B. WING		07/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADISON HEALTHCARE SERVICES			ND AVENUE , MN 56256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21665	department was un repair needs. Follow maintenance sched verified the areas with The ED stated the fidentify and repair fixeeping problems, overlooked the idenbecomes common same environment quarterly audit of the for the end of the more that time.  The facility policy tith Program, revised 1 was to provide the funinterrupted maintenance and for the director of nursing (educate staff regard clean, functional and DON or designee, of maintenance and his periodic audits of all ensure a safe, cleatenvironment is maintenance in the control of th	ned the maintenance aware of the aforementioned wing review of the duled assignments, the ED vere not scheduled for repair. facility had a plan in place to acility maintenance and house however, staff may have ntified repair needs as it place when working in the daily. The ED stated a e entire facility was scheduled nonth and he believed these would have been identified at the deleter of the daily.	21665			

6899