DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TNDA

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00329

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245382**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON HEALTHCARE SERVICES**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/08/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, HFE NEII 10/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/11/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/25/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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 Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

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

ID: TNDA

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L3) **MADISON HEALTHCARE SERVICES**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE NEII 08/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/25/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

Remedies - 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;

Potential Consequences - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		8/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 279	The facility will develop and implement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	07/20/2017

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

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F 279	Continued From page 2 review, the facility failed to develop a care plan which identified chronic facial lesions for 1 of 3 residents (R4) reviewed for non-pressure related skin concerns. Findings include: A quarterly Minimum Data Set (MDS) dated 6/2/17, revealed R4 had diagnoses which include hemiplegia, depression, aphasia, long-term use of anticoagulants (blood thinning medication), and had moderate impaired cognition. The resident required extensive assist of one person with Activity of Daily Living including bed mobility, transferring, and toileting. R4's care plan revised 7/24/14, identified "I have the potential for impairment to skin integrity. Interventions included, avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Booties to heels, when compliant, keep heels floated when in bed or recliner. Educate resident/family/caregivers of causative factor and measures to prevent skin injury. Identify/document potential causative factors and eliminate /resolve where possible. Keep skin clean and dry. Use lotion on dry skin. Pressure redistribution cushion in wheelchair and recliner. Weekly skin inspections, document findings and report to provider as needed. The care plan did not address facial lesions and interventions. Care conference note dated 5/31/17, indicated R4 continued to have cancer lesions on face, declined follow up with surgeon to discuss possible removal. Further, the note indicated R4 used hydrocortisone to decrease itching and reduce him picking and scratching areas. The	F 279	comprehensive person-centered care plans, based on identified, individualized needs through a comprehensive assessment for all facility residents. On July 19, 2017, resident R4□s care plan has been modified to include a problem/need of non-pressure cancer lesions on the face and resident□s picking of the lesions. A goal has been developed for the cancer lesions and interventions developed and implemented for these lesions. The plan will be evaluated, reviewed and revised as needed. All resident care plans will be reviewed and revised to include all identified needs and services to attain the highest level of functioning and quality of life for residents. Education with staff was completed on August 2, 2017. Quality Assurance and Performance Improvement audits of the care plans will be completed monthly to ensure ongoing compliance. The Director of Nursing, or designee, will be responsible for completing audits of the care plan and brought to QAPI meeting..	

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note identified R4's skin at risk and indicated R4 self-administered the hydrocortisone cream.

R4's current physician orders signed 6/29/17, directed the administration of hydrocortisone 1% cream. apply tid (three times per day) to facial lesions. patient may have in his room.

Physician progress note dated 9/23/16, indicated R4 had facial lesions that he tended to pick at, and questioned if they were chronic or self induced. The physician believed it was most likely a combination.

Physician progress note dated 1/12/17, R4 had a sore on his right cheek and lower left cheek, and had been there for quite some time. The note indicated R4 tended to pick at his sores, and the left cheek sore had progressed and worsened slightly. Left lower cheek measured 1.0 cm (centimeter) x 1.0 cm x 0.5 cm ulcerated area. Right cheek had scaling, mild erythema, edema over mid right upper cheek. Right lesions is without ulceration, skin breakdown or drainage. The physician documented the skins lesions were most likely basal cell carcinoma, and would have patient visit with surgery for excision.

Consultation visit dated 1/20/17, indicated R4 likely had 3 areas of cancer of his face, discussed surgical options with R4 and education was given with no treatment the areas would likely have slow progression. The note indicated R4's lesions have been present for approximately the last four years without resolution. Follow-up appointment was scheduled for 2/3/17, which R4 and his wife refused to attend.

Physician progress note dated 3/9/17, indicated

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R4 completed the consultation visit with surgery for possible lesion removed, and deferred that option. R4 requested a cream to use on his facial lesions daily, and continued with anxiety and picking the facial lesions. Hydrocortisone 1% cream to be applied three times daily to facial lesions was ordered. R4 was given the order that he may have that medication in his room.

Physician progress note dated 5/5/17, indicated R4 was to continue using the Hydrocortisone 1% cream to the lesions on his face. R4 was seen by surgery and was recommended to have them removed but R4 declined and continues to defer any type of intervention. Continue to use hydrocortisone 1% cream to affected areas two times per day.

Physician progress note dated 6/29/17, indicated R4 was able to see surgery about his left sided facial lesion, but deferred all options given to him. Indicated he does not want anything further done at this time. Continue to use the hydrocortisone 1% cream to affected areas twice per day.

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 has been performed. 2 freeze thaw cycles were performed on each lesion, R4 tolerated the procedure well, and recommended to return to the clinic again 8 weeks for continued treatment.

On 7/17/17, at 4:58 p.m. R4 was observed with

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an open area on his left cheek next to his nose, the area was shiny and weeping clear liquid. There were other red areas around R4's nose which we intact. R4 touched the areas on his face and stated they did not bother him, and reported the spots come and go.

On 7/19/17, at 7:17 a.m. R4 was observed in a wheelchair in the dining room, and had multiple sores on his face, one open area on his left and right cheek, and one open area on the left side of his nose. R4 also was observed to have multiple areas of redness in these areas.

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.

On 7/19/17, at 2:00 p.m. the assistant director of nursing (ADON) delivered a completed non-pressure ulcer skin condition assessments for R4 dated 7/19/17. The ADON reported the hydrocortisone order had been discontinued effective 7/19/17.
-right cheek, 1.0 x 1.6 cm-open area, covered with bandaids after cryotherapy,
-top of nose, 1.4 cm x 2.4 cm, flat red
-left cheek, red area 2.0 cm 5.0 cm, open area 0.7 cm x 1.5 cm
-left corner of nose 7.0 x 4.0 with a 2.0 mm depth
-left of nose, flat and red, 2.0 x 1.7

On 7/19/17, at 2:19 p.m. nursing assistant (NA)-A stated R4 picked his face a lot, and confirmed he has had the lesions on his face for quite some time.

On 7/19/17, at 7:44 a.m. R4 denied any pain in or

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around his face where the facial lesions were present. R4 stated the sores did not bother him, he did agree it was hard for him to not pick them. R4 indicated the sores had been present on his face for quite some time. When interviewed on 7/17/17, at 4:58 p.m. R4 and his wife reported the areas on his face come and go, and have been there now for a long time.

On 7/19/17, at 11:48 a.m. licensed practical nurse (LPN)-B confirmed she was R4's nurse today and worked with R4 frequently. LPN-B stated R4 was a picker, and had a hard time leaving the facial lesions alone. LPN-B could not confirm size of the facial lesions, the description, the progression of healing or how long the lesions had been present on R4's face. LPN-B stated the sores come and go, then stated the sores were cancer. LPN-B reported R4 had been to the doctor a while back and R4 and family decided not to treat the sores.

On 7/19/17, at 11:50 p.m. CM-A verified R4's care plan lacked any documentation regarding the chronic facial lesions, chronic picking , goals or interventions, CM-A stated the care plan failed to identity this concern all together.

07/20/17, at 11:42 a.m. the director of nursing (DON) confirmed she would expect these skin concerns and the resident's chronic picking to have been identified on his care plan, and stated he was at high risk given his co-morbidities with his anticoagulation use as well.

The facility's care plan policy dated 5/2017, indicated all resident would have a plan of care, and would be reviewed and revised at least quarterly and as needed based on

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F 279	Continued From page 7 comprehensive assessments.	F 279		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		8/29/17

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor reoccurring facial skin lesions for 1 of 1 resident (R4) reviewed for non pressure related skin conditions. Findings include: A quarterly Minimum Data Set (MDS) dated 6/2/17, revealed R4 had diagnoses which include hemiplegia, depression, aphasia, long-term use of anticoagulants (blood thinning medication), and had moderate impaired cognition. The resident required extensive assist of one person with Activity of Daily Living including bed mobility, transferring, and toileting. Care conference note dated 5/31/17, indicated R4 continued to have cancer lesions on face, declined follow up with surgeon to discuss possible removal. Further, the note indicated R4 used hydrocortisone to decrease itching and reduce him picking and scratching areas. The note identified R4's skin at risk and indicated R4 self-administered the hydrocortisone cream. R4's current physician orders signed 6/29/17, directed the administration of hydrocortisone 1% cream. apply tid (three times per day) to facial lesions. Patient may have in his room. R4's care plan revised 7/24/14, indicated R4 had the potential for impairment to skin integrity. Interventions indicated R4 was to avoid scratching, was to keep hands and body parts from excessive moisture, keep fingernails short, booties to heels, when compliant, and to keep	F 309	Each resident will receive the necessary care and services to attain and maintain the highest level of well-being as identified in the comprehensive assessment plan of care. R4 received cryotherapy to facial skin lesions on July 19, 2017. A plan of care for the lesions has been developed and implemented. Visualization, assessments and documentation of the lesions is done at least weekly. Staff education was completed on August 2, 2017. A policy and procedure for tracking of non-pressure skin conditions was reviewed and revised. Quality assurance and performance improvement audits of non-pressure skin concerns will be completed monthly to ensure ongoing compliance. It will be the responsibility of the Director of Nursing, or designee, to ensure these are audits are completed and brought to QAPI meeting.	

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heels floated when in bed or recliner. Staff were to educate resident/family/caregivers of causative factor and measures to prevent skin injury. Identify/document potential causative factors and eliminate /resolve where possible. Keep skin clean and dry, use lotion on dry skin, and pressure redistribution cushion in wheelchair and recliner. Weekly skin inspections, document findings and report to provider as needed. The care plan failed to address R4's chronic facial lesions, any goals or interventions.

Review of the following facility documentation lacked monitoring of R4's facial lesions and monitoring of the prescribed medication for R4's facial lesions:

-Nursing progress notes dated from 9/1/16, to 7/18/17, (with the exception of referencing physician visits)
-Non-Pressure Ulcer Skin Conditions dated 9/1/16, to 7/18/17
-Treatment Administration Records dated from 3/1/17, to 7/18/17
-Medication Administration Records dated from 3/1/17, to 7/18/17
-R4's care plan targeted date of 8/28/17
-Weekly visual skin inspection notes from 9/1/16, to 7/16/17, were reviewed. One note dated 1/8/17, indicated an open area noted to face, area cleansed, lotion applied. One note dated 3/12/17, indicated R4 had lesions of face and were stable, under treatment ordered by the physician, no new area of concern. All other notes indicated a visual inspection of R4's skin had been completed with no new areas of concern. No measurements or description was documented on the 1/8/17, or 3/12/17, note.

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Physician progress note dated 9/23/16, indicated R4 had facial lesions that he tended to pick at, and questioned if they were chronic or self induced. The physician believed it was most likely a combination.

Physician progress note dated 1/12/17, R4 had a sore on his right cheek and lower left cheek, and had been there for quite some time. The note indicated R4 tended to pick at his sores, and the left cheek sore had progressed and worsened slightly. Left lower cheek measured 1.0 cm (centimeter) x 1.0 cm x 0.5 cm ulcerated area. Right cheek had scaling, mild erythema, edema over mid right upper cheek. Right lesions is without ulceration, skin breakdown or drainage. The physician documented the skins lesions were most likely basal cell carcinoma, and would have patient visit with surgery for excision.

Consultation visit dated 1/20/17, indicated R4 likely had 3 areas of cancer of his face, discussed surgical options with R4 and education was given with no treatment the areas would likely have slow progression. The note indicated R4's lesions have been present for approximately the last four years without resolution. Follow-up appointment was scheduled for 2/3/17, which R4 and his wife refused to attend.

Physician progress note dated 3/9/17, indicated R4 completed the consultation visit with surgery for possible lesion removed, and deferred that option. R4 requested a cream to use on his facial lesions daily, and continued with anxiety and picking the facial lesions. Hydrocortisone 1% cream to be applied three times daily to facial lesions was ordered. R4 was given the order that he may have that medication in his room.

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Physician progress note dated 5/5/17, indicated R4 was to continue using the Hydrocortisone 1% cream to the lesions on his face. R4 was seen by surgery and was recommended to have them removed but R4 declined and continues to defer any type of intervention. Continue to use hydrocortisone 1% cream to affected areas two times per day.

Physician progress note dated 6/29/17, indicated R4 was able to see surgery about his left sided facial lesion, but deferred all options given to him. Indicated he does not want anything further done at this time. Continue to use the hydrocortisone 1% cream to affected areas twice per day.

On 7/17/17, at 4:58 p.m. R4 was observed with an open area on his left cheek next to his nose, the area was shiny and weeping clear fluid. There were other red areas around R4's nose which were intact. R4 touched the areas on his face and stated they did not bother him, and stated the spots come and go.

On 7/19/17, at 7:17 a.m. R4 was observed in a wheelchair in the dining room, and had multiple sores on his face, one open area on his left and right cheek, and one open area on the left side of his nose. R4 also was observed to have multiple areas of redness in these areas.

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

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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.

On 7/19/17, at 2:00 p.m. the assistant director of nursing (ADON) delivered completed non-pressure ulcer skin condition assessments for R4 dated 7/19/17. The ADON reported the hydrocortisone order had been discontinued effective 7/19/17.
-right cheek, 1.0 x 1.6 centimeter (cm)-open area, covered with bandaids after cryotherapy,
-top of nose, 1.4 cm x 2.4 cm, flat red
-left cheek, red area 2.0 cm 5.0 cm, open area 0.7 cm x 1.5 cm
-left corner of nose 7.0 x 4.0 with a 2.0 millimeter (mm) depth
-left of nose, flat and red, 2.0 x 1.7

On 7/19/17, at 7:43 a.m. CM-A reported R4 finally agreed to go to the doctor for cryotherapy, to have the facial lesions removed. CM-A stated R4 has had the facial lesions before and have healed on their own, stated it depended how fast the sores healed because R4 would touch them frequently and need reminders to not touch the areas. CM-A denied the sores bleeding unless R4 would pick them.

On 7/19/17, at 2:19 p.m. nursing assistant (NA)-A stated R4 picked his face a lot, and confirmed he

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has had the lesions on his face for quite some time.

On 7/19/17, at 7:44 a.m. R4 denied any pain in or around his face where the facial lesions were present. R4 stated the sores did not bother him, he did agree it was hard for him to not pick them. R4 indicated the sores had been present on his face for quite some time. When interviewed on 7/17/17, at 4:58 p.m. R4 and his wife reported the areas on his face came and went, and have been there now for a long time.

On 7/19/17, at 11:48 a.m. licensed practical nurse (LPN)-B confirmed she was R4's nurse today and worked with R4 frequently. LPN-B stated R4 was a picker, and had a hard time leaving the facial lesions alone. LPN-B could not confirm size of the facial lesions, the description, the progression of healing or how long the lesions had been present on R4's face. LPN-B verified staff never started the weekly non-pressure ulcer skin condition tool which would have tracked the progress and treatment of each area. LPN-B stated the sores come and go, then stated the sores were cancer. LPN-B reported R4 had been to the doctor a while back and R4 and family decided not to treat the sores, then stated R4 did have an appointment today for cyrotherapy, and has another one set up in 8 weeks. LPN-B stated 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

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F 309	Continued From page 14	F 309		

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.

On 7/19/17, at 11:50 p.m. CM-A confirmed staff never implemented the monitoring tool for R4's facial lesions, and stated i will start the wound sheets now. CM-A stated staff usually start one when a resident has an open area to monitor for healing. CM-A verified there was no documentation from the facility other than the general weekly skin note, which did not include any specific information regarding R4's facial lesions. CM-A verified due to the lack of documentation, staff were unable to determine the progression of the multiple areas on R4's face. CM-A was not aware of R4's prescribed hydrocortisone order on 3/9/17 and stated the order is still active. CM-A confirmed staff had not been monitoring the use or lack of use of the medication. CM-A also verified R4's care plan lacked any documenting regarding the chronic facial lesions, chronic picking , goals or interventions, CM-A stated the care plan failed to identity this concern all together.

07/20/17, at 11:42 a.m. the director of nursing (DON) verified she expected staff to document

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	245382	A. BUILDING _____ B. WING _____	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 and monitor all non pressure related skin concerns, and reported staff should have been monitoring R4's facial skin lesions for signs and symptoms of infections and should have been measuring the open areas as they opened and documented them as they healed, as these areas were chronic and would come and go. In addition, the DON stated she expected staff to monitor the usage of the hydrocortisone cream which he had been prescribed to use in his room. The DON also reported she would expect these skin concerns and the resident's chronic picking to have been identified on his care plan, and stated he was at high risk given his co-morbidities with his anticoagulation use as well. The facility's non-pressure ulcer skin conditions form procedure policy dated 2007, indicated staff would fill out the form on any skin concern that was not a pressure ulcer, arterial wound, venous wound, or neuropathy/diabetic wound. The policy indicated the form would be filled out upon discovery of skin condition and then at least weekly thereafter, only one skin condition per for. Once the skin area was healed, the non-pressure ulcer skin condition form was to be filed into the resident medical record.	F 309		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441		8/29/17

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F 441	Continued From page 16 investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 441		

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F 441	Continued From page 17 contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were properly maintained while storing ice packs with ready to eat foods in 1 of 2 kitchenettes. Findings include: During dining observation on 7/17/17, at 5:21 p.m. the refrigerator in the kitchenette on Station One was noted to have three blue re-usable ice packs located on the top shelf and bottom of the freezer. Two blue re-usable ice packs were laying on the top shelf a few inches away from fourteen strawberry swirl and six chocolate swirl ready to eat individual ice cream cups on the top freezer shelf. One blue re-usable ice pack was on the bottom of the freezer, partially lying on a brown paper bag containing six Dairy Queen dilly bars. There also were three ready to eat sherbet cups	F 441	An infection prevention and control program has been established. A policy and procedure for storage of resident care items including ice packs has been developed. The noted ice packs were immediately put into storage bags at the time this problem was identified on July 17, 2017. The facility no longer uses re-usable ice packs and instead will use disposable packs. Staff education was completed on August 2, 2017. Quality assurance audits of facility refrigerators and freezers will be completed at least monthly to ensure ongoing compliance. The Director of Nursing, or designee, will be responsible for ensuring these audits are completed and brought to QAPI meeting.	

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F 441	Continued From page 18 on the bottom of the freezer. On 7/17/17, at 5:23 p.m. licensed practical nurse (LPN)-A visualized the Station One freezer and confirmed the above findings. LPN-A confirmed the re-usable ice packs were used on a resident body when a resident in the facility had physician orders for ice packs or as needed for injury from falls or lower back pain. LPN-A also indicated they used a towel or sleeve to cover the ice packs when they used them on resident. LPN -A indicated she cleaned the ice packs after use with sanitization wipes. 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.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		8/29/17

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F 465	Continued From page 19 (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and sanitary condition in resident rooms and bathrooms for 9 of 30 resident rooms (South 107,113,125,127, West 115, 123, 125, 127, 135) reviewed. Findings include: On 7/19/17, at 12:22 p.m. during the environmental tour with the environmental director (ED) the following environmental concerns were observed: South hall: Room 107: the lower portion of the bathroom wall had multiple round gouges out of the sheet rock measuring approximately two inches in diameter. Room 113: the bathroom sink faucets had heavy build up of lime scale. 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	F 465	The facility will provide education to staff on the importance of reporting damage to walls, faucet corrosion, etc. along with the process of reporting. This education will be completed by August 29, 2017. The policy titled, Preventative Maintenance Program, has been reviewed and revised to change the frequency of preventative maintenance audits from quarterly to monthly. The Environmental Services Director, or designee, will be responsible for audits being completed and brought the Quality Assurance Performance Improvement committee. Completed audits will be brought to QAPI at least quarterly to ensure ongoing compliance. Room 107: Bathroom wall gouges have 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 been replaced. Completed August 10, 2017. The bathroom door has been sanded, stained and varnished. Completed on August 14, 2017. The sheet rock around the fan coil unit will be replaced and painted. The fan coil unit will be sanded, cleaned and painted. Completed August 29, 2017.	

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F 465	Continued From page 20 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. On 7/19/17, at 12:22 p.m. the ED verified the findings and confirmed the maintenance department was unaware of the aforementioned repair needs. Following review of the maintenance scheduled assignments, the ED verified the areas were not scheduled for repair.	F 465	Room 127: The floor was scrubbed and buffed to repair damages. Completed July 31, 2017. The sheet rock was repaired by patching and painting. Completed July 27, 2017. Room 115: Sink faucet parts have been replaced. Completed July 27, 2017. Room 123: The hole and gouges noted will be patched and painted. Completed August 18, 2017. Room 135: The two holes were patched and painted. Completed July 26, 2017.	

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F 465	Continued From page 21 The ED stated the facility had a plan in place to identify and repair facility maintenance and house keeping problems, however, staff may have overlooked the identified repair needs as it becomes common place when working in the same environment daily. The ED stated a quarterly audit of the entire facility was scheduled for the end of the month and he believed these problems and more would have been identified at that time. The facility policy titled Preventive Maintenance Program, revised 11/16, indicated the purpose was to provide the facility with quality, uninterrupted maintenance service 24 hours a day.	F 465		

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 19, 2017. At the time of this survey, Madison Healthcare Services Nursing Home was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Madison Healthcare Services Nursing Home is a 3-story building with partial basement, and is fully fire sprinkler protected. The original building was constructed in 1914 and was determined to be of Type I(322) construction. The 1952 addition was determined to be of Type I(332) construction. The 1968 addition was determined to be of Type II(111) construction. The 1977 addition was determined to be of Type II(111) construction. The 1991 addition was determined to be of Type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The 1914 and 1952 buildings are a "B" Occupancy. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored fr automatic fire department notification. The facility has a capacity of 65 beds and had a census of 56 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2017**

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DEPARTMENT OF HEALTH

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	07/20/2017

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates 7/17/17, 7/18/17, 7/19/17, and 7/20/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan which identified chronic facial lesions for 1 of 3 residents (R4) reviewed for non-pressure related skin concerns. Findings include: A quarterly Minimum Data Set (MDS) dated 6/2/17, revealed R4 had diagnoses which include hemiplegia, depression, aphasia, long-term use of anticoagulants (blood thinning medication), and had moderate impaired cognition. The resident required extensive assist of one person with Activity of Daily Living including bed mobility, transferring, and toileting.	2 560	Corrected	9/1/17

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

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2 560	Continued From page 3	2 560		

R4's care plan revised 7/24/14, identified "I have the potential for impairment to skin integrity. Interventions included, avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Booties to heels, when compliant, keep heels floated when in bed or recliner. Educate resident/family/caregivers of causative factor and measures to prevent skin injury. Identify/document potential causative factors and eliminate /resolve where possible. Keep skin clean and dry. Use lotion on dry skin. Pressure redistribution cushion in wheelchair and recliner. Weekly skin inspections, document findings and report to provider as needed. The care plan did not address facial lesions and interventions.

Care conference note dated 5/31/17, indicated R4 continued to have cancer lesions on face, declined follow up with surgeon to discuss possible removal. Further, the note indicated R4 used hydrocortisone to decrease itching and reduce him picking and scratching areas. The note identified R4's skin at risk and indicated R4 self-administered the hydrocortisone cream.

R4's current physician orders signed 6/29/17, directed the administration of hydrocortisone 1% cream. apply tid (three times per day) to facial lesions. patient may have in his room.

Physician progress note dated 9/23/16, indicated R4 had facial lesions that he tended to pick at, and questioned if they were chronic or self induced. The physician believed it was most likely a combination.

Physician progress note dated 1/12/17, R4 had a sore on his right cheek and lower left cheek, and had been there for quite some time. The note

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2 560	Continued From page 4 indicated R4 tended to pick at his sores, and the left cheek sore had progressed and worsened slightly. Left lower cheek measured 1.0 cm (centimeter) x 1.0 cm x 0.5 cm ulcerated area. Right cheek had scaling, mild erythema, edema over mid right upper cheek. Right lesions is without ulceration, skin breakdown or drainage. The physician documented the skins lesions were most likely basal cell carcinoma, and would have patient visit with surgery for excision. Consultation visit dated 1/20/17, indicated R4 likely had 3 areas of cancer of his face, discussed surgical options with R4 and education was given with no treatment the areas would likely have slow progression. The note indicated R4's lesions have been present for approximately the last four years without resolution. Follow-up appointment was scheduled for 2/3/17, which R4 and his wife refused to attend. Physician progress note dated 3/9/17, indicated R4 completed the consultation visit with surgery for possible lesion removed, and deferred that option. R4 requested a cream to use on his facial lesions daily, and continued with anxiety and picking the facial lesions. Hydrocortisone 1% cream to be applied three times daily to facial lesions was ordered. R4 was given the order that he may have that medication in his room. Physician progress note dated 5/5/17, indicated R4 was to continue using the Hydrocortisone 1% cream to the lesions on his face. R4 was seen by surgery and was recommended to have them removed but R4 declined and continues to defer any type of intervention. Continue to use hydrocortisone 1% cream to affected areas two times per day.	2 560		

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2 560	Continued From page 5 Physician progress note dated 6/29/17, indicated R4 was able to see surgery about his left sided facial lesion, but deferred all options given to him. Indicated he does not want anything further done at this time. Continue to use the hydrocortisone 1% cream to affected areas twice per day. 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 has been performed. 2 freeze thaw cycles were performed on each lesion, R4 tolerated the procedure well, and recommended to return to the clinic again 8 weeks for continued treatment. On 7/17/17, at 4:58 p.m. R4 was observed with an open area on his left cheek next to his nose, the area was shiny and weeping clear liquid. There were other red areas around R4's nose which we intact. R4 touched the areas on his face and stated they did not bother him, and reported the spots come and go. On 7/19/17, at 7:17 a.m. R4 was observed in a wheelchair in the dining room, and had multiple sores on his face, one open area on his left and right cheek, and one open area on the left side of his nose. R4 also was observed to have multiple areas of redness in these areas. 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.	2 560		

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2 560	Continued From page 6 On 7/19/17, at 2:00 p.m. the assistant director of nursing (ADON) delivered a completed non-pressure ulcer skin condition assessments for R4 dated 7/19/17. The ADON reported the hydrocortisone order had been discontinued effective 7/19/17. -right cheek, 1.0 x 1.6 cm-open area, covered with bandaids after cryotherapy, -top of nose, 1.4 cm x 2.4 cm, flat red -left cheek, red area 2.0 cm 5.0 cm, open area 0.7 cm x 1.5 cm -left corner of nose 7.0 x 4.0 with a 2.0 mm depth -left of nose, flat and red, 2.0 x 1.7 On 7/19/17, at 2:19 p.m. nursing assistant (NA)-A stated R4 picked his face a lot, and confirmed he has had the lesions on his face for quite some time. On 7/19/17, at 7:44 a.m. R4 denied any pain in or around his face where the facial lesions were present. R4 stated the sores did not bother him, he did agree it was hard for him to not pick them. R4 indicated the sores had been present on his face for quite some time. When interviewed on 7/17/17, at 4:58 p.m. R4 and his wife reported the areas on his face come and go, and have been there now for a long time. On 7/19/17, at 11:48 a.m. licensed practical nurse (LPN)-B confirmed she was R4's nurse today and worked with R4 frequently. LPN-B stated R4 was a picker, and had a hard time leaving the facial lesions alone. LPN-B could not confirm size of the facial lesions, the description, the progression of healing or how long the lesions had been present on R4's face. LPN-B stated the sores come and go, then stated the sores were cancer. LPN-B reported R4 had been to the doctor a while back and R4 and family decided not to treat	2 560		

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2 560	Continued From page 7 the sores. On 7/19/17, at 11:50 p.m. CM-A verified R4's care plan lacked any documentation regarding the chronic facial lesions, chronic picking , goals or interventions, CM-A stated the care plan failed to identity this concern all together. 07/20/17, at 11:42 a.m. the director of nursing (DON) confirmed she would expect these skin concerns and the resident's chronic picking to have been identified on his care plan, and stated he was at high risk given his co-morbidities with his anticoagulation use as well. The facility's care plan policy dated 5/2017, indicated all resident would have a plan of care, and would be reviewed and revised at least quarterly and as needed based on comprehensive assessments. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the development of comprehensive care plans. The DON or designee, could provide training for all nursing staff related to the development of comprehensive care plans. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		9/1/17

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2 830	Continued From page 8 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor reoccurring facial skin lesions for 1 of 1 resident (R4) reviewed for non pressure related skin conditions. Findings include: A quarterly Minimum Data Set (MDS) dated 6/2/17, revealed R4 had diagnoses which include hemiplegia, depression, aphasia, long-term use of anticoagulants (blood thinning medication), and had moderate impaired cognition. The resident required extensive assist of one person with Activity of Daily Living including bed mobility, transferring, and toileting. Care conference note dated 5/31/17, indicated R4 continued to have cancer lesions on face, declined follow up with surgeon to discuss possible removal. Further, the note indicated R4 used hydrocortisone to decrease itching and reduce him picking and scratching areas. The	2 830	Corrected	

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2 830	Continued From page 9 note identified R4's skin at risk and indicated R4 self-administered the hydrocortisone cream. R4's current physician orders signed 6/29/17, directed the administration of hydrocortisone 1% cream. apply tid (three times per day) to facial lesions. Patient may have in his room. R4's care plan revised 7/24/14, indicated R4 had the potential for impairment to skin integrity. Interventions indicated R4 was to avoid scratching, was to keep hands and body parts from excessive moisture, keep fingernails short, booties to heels, when compliant, and to keep heels floated when in bed or recliner. Staff were to educate resident/family/caregivers of causative factor and measures to prevent skin injury. Identify/document potential causative factors and eliminate /resolve where possible. Keep skin clean and dry, use lotion on dry skin, and pressure redistribution cushion in wheelchair and recliner. Weekly skin inspections, document findings and report to provider as needed. The care plan failed to address R4's chronic facial lesions, any goals or interventions. Review of the following facility documentation lacked monitoring of R4's facial lesions and monitoring of the prescribed medication for R4's facial lesions: -Nursing progress notes dated from 9/1/16, to 7/18/17, (with the exception of referencing physician visits) -Non-Pressure Ulcer Skin Conditions dated 9/1/16, to 7/18/17 -Treatment Administration Records dated from 3/1/17, to 7/18/17 -Medication Administration Records dated from 3/1/17, to 7/18/17	2 830		

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2 830	Continued From page 10 -R4's care plan targeted date of 8/28/17 -Weekly visual skin inspection notes from 9/1/16, to 7/16/17, were reviewed. One note dated 1/8/17, indicated an open area noted to face, area cleansed, lotion applied. One note dated 3/12/17, indicated R4 had lesions of face and were stable, under treatment ordered by the physician, no new area of concern. All other notes indicated a visual inspection of R4's skin had been completed with no new areas of concern. No measurements or description was documented on the 1/8/17, or 3/12/17, note. Physician progress note dated 9/23/16, indicated R4 had facial lesions that he tended to pick at, and questioned if they were chronic or self induced. The physician believed it was most likely a combination. Physician progress note dated 1/12/17, R4 had a sore on his right cheek and lower left cheek, and had been there for quite some time. The note indicated R4 tended to pick at his sores, and the left cheek sore had progressed and worsened slightly. Left lower cheek measured 1.0 cm (centimeter) x 1.0 cm x 0.5 cm ulcerated area. Right cheek had scaling, mild erythema, edema over mid right upper cheek. Right lesions is without ulceration, skin breakdown or drainage. The physician documented the skins lesions were most likely basal cell carcinoma, and would have patient visit with surgery for excision. Consultation visit dated 1/20/17, indicated R4 likely had 3 areas of cancer of his face, discussed surgical options with R4 and education was given with no treatment the areas would likely have slow progression. The note indicated R4's lesions have been present for approximately the last four years without resolution. Follow-up	2 830		

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2 830	Continued From page 11 appointment was scheduled for 2/3/17, which R4 and his wife refused to attend. Physician progress note dated 3/9/17, indicated R4 completed the consultation visit with surgery for possible lesion removed, and deferred that option. R4 requested a cream to use on his facial lesions daily, and continued with anxiety and picking the facial lesions. Hydrocortisone 1% cream to be applied three times daily to facial lesions was ordered. R4 was given the order that he may have that medication in his room. Physician progress note dated 5/5/17, indicated R4 was to continue using the Hydrocortisone 1% cream to the lesions on his face. R4 was seen by surgery and was recommended to have them removed but R4 declined and continues to defer any type of intervention. Continue to use hydrocortisone 1% cream to affected areas two times per day. Physician progress note dated 6/29/17, indicated R4 was able to see surgery about his left sided facial lesion, but deferred all options given to him. Indicated he does not want anything further done at this time. Continue to use the hydrocortisone 1% cream to affected areas twice per day. On 7/17/17, at 4:58 p.m. R4 was observed with an open area on his left cheek next to his nose, the area was shiny and weeping clear fluid. There were other red areas around R4's nose which were intact. R4 touched the areas on his face and stated they did not bother him, and stated the spots come and go. On 7/19/17, at 7:17 a.m. R4 was observed in a wheelchair in the dining room, and had multiple sores on his face, one open area on his left and	2 830		

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2 830	Continued From page 12	2 830		

right cheek, and one open area on the left side of his nose. R4 also was observed to have multiple areas of redness in these areas.

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.

On 7/19/17, at 2:00 p.m. the assistant director of nursing (ADON) delivered completed non-pressure ulcer skin condition assessments for R4 dated 7/19/17. The ADON reported the hydrocortisone order had been discontinued effective 7/19/17.
-right cheek, 1.0 x 1.6 centimeter (cm)-open area, covered with bandaids after cryotherapy,
-top of nose, 1.4 cm x 2.4 cm, flat red
-left cheek, red area 2.0 cm 5.0 cm, open area 0.7 cm x 1.5 cm
-left corner of nose 7.0 x 4.0 with a 2.0 millimeter (mm) depth
-left of nose, flat and red, 2.0 x 1.7

On 7/19/17, at 7:43 a.m. CM-A reported R4 finally agreed to go to the doctor for cryotherapy, to

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2 830	Continued From page 13	2 830		

have the facial lesions removed. CM-A stated R4 has had the facial lesions before and have healed on their own, stated it depended how fast the sores healed because R4 would touch them frequently and need reminders to not touch the areas. CM-A denied the sores bleeding unless R4 would pick them.

On 7/19/17, at 2:19 p.m. nursing assistant (NA)-A stated R4 picked his face a lot, and confirmed he has had the lesions on his face for quite some time.

On 7/19/17, at 7:44 a.m. R4 denied any pain in or around his face where the facial lesions were present. R4 stated the sores did not bother him, he did agree it was hard for him to not pick them. R4 indicated the sores had been present on his face for quite some time. When interviewed on 7/17/17, at 4:58 p.m. R4 and his wife reported the areas on his face came and went, and have been there now for a long time.

On 7/19/17, at 11:48 a.m. licensed practical nurse (LPN)-B confirmed she was R4's nurse today and worked with R4 frequently. LPN-B stated R4 was a picker, and had a hard time leaving the facial lesions alone. LPN-B could not confirm size of the facial lesions, the description, the progression of healing or how long the lesions had been present on R4's face. LPN-B verified staff never started the weekly non-pressure ulcer skin condition tool which would have tracked the progress and treatment of each area. LPN-B stated the sores come and go, then stated the sores were cancer. LPN-B reported R4 had been to the doctor a while back and R4 and family decided not to treat the sores, then stated R4 did have an appointment today for cryotherapy, and has another one set up in 8 weeks. LPN-B stated

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2 830	Continued From page 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.

On 7/19/17, at 11:50 p.m. CM-A confirmed staff never implemented the monitoring tool for R4's facial lesions, and stated i will start the wound sheets now. CM-A stated staff usually start one when a resident has an open area to monitor for healing. CM-A verified there was no documentation from the facility other than the general weekly skin note, which did not include any specific information regarding R4's facial lesions. CM-A verified due to the lack of documentation, staff were unable to determine the progression of the multiple areas on R4's face. CM-A was not aware of R4's prescribed hydrocortisone order on 3/9/17 and stated the order is still active. CM-A confirmed staff had not been monitoring the use or lack of use of the

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

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2 830	Continued From page 15 medication. CM-A also verified R4's care plan lacked any documenting regarding the chronic facial lesions, chronic picking , goals or interventions, CM-A stated the care plan failed to identity this concern all together. 07/20/17, at 11:42 a.m. the director of nursing (DON) verified she expected staff to document and monitor all non pressure related skin concerns, and reported staff should have been monitoring R4's facial skin lesions for signs and symptoms of infections and should have been measuring the open areas as they opened and documented them as they healed, as these areas were chronic and would come and go. In addition, the DON stated she expected staff to monitor the usage of the hydrocortisone cream which he had been prescribed to use in his room. The DON also reported she would expect these skin concerns and the resident's chronic picking to have been identified on his care plan, and stated he was at high risk given his co-morbidities with his anticoagulation use as well. The facility's non-pressure ulcer skin conditions form procedure policy dated 2007, indicated staff would fill out the form on any skin concern that was not a pressure ulcer, arterial wound, venous wound, or neuropathy/diabetic wound. The policy indicated the form would be filled out upon discovery of skin condition and then at least weekly thereafter, only one skin condition per for. Once the skin area was healed, the non-pressure ulcer skin condition form was to be filed into the resident medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and	2 830		

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2 830	Continued From page 16 procedures related to development of plan of care for non pressure ulcer skin assessments and monitoring, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were properly maintained while storing ice packs with ready to eat foods in 1 of 2 kitchenettes. Findings include: During dining observation on 7/17/17, at 5:21 p.m. the refrigerator in the kitchenette on Station One was noted to have three blue re-usable ice packs located on the top shelf and bottom of the freezer. Two blue re-usable ice packs were laying on the top shelf a few inches away from fourteen strawberry swirl and six chocolate swirl ready to eat individual ice cream cups on the top freezer shelf. One blue re-usable ice pack was on the bottom of the freezer, partially lying on a brown paper bag containing six Dairy Queen dilly bars.	21375	Corrected	9/1/17

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21375	Continued From page 17 There also were three ready to eat sherbet cups on the bottom of the freezer. On 7/17/17, at 5:23 p.m. licensed practical nurse (LPN)-A visualized the Station One freezer and confirmed the above findings. LPN-A confirmed the re-usable ice packs were used on a resident body when a resident in the facility had physician orders for ice packs or as needed for injury from falls or lower back pain. LPN-A also indicated they used a towel or sleeve to cover the ice packs when they used them on resident. LPN -A indicated she cleaned the ice packs after use with sanitization wipes. 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to infection control and prevention of cross contamination with ice pack storage, provide training for all nursing staff , and the quality assessment and assurance committee could perform random audits to ensure compliance.	21375		

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21375	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and sanitary condition in resident rooms and bathrooms for 9 of 30 resident rooms (South 107, 113, 125, 127, West 115, 123, 125, 127, 135) reviewed. Findings include: On 7/19/17, at 12:22 p.m. during the environmental tour with the environmental director (ED) the following environmental concerns were observed: South hall: Room 107: the lower portion of the bathroom wall had multiple round gouges out of the sheet rock measuring approximately two inches in diameter. Room 113: the bathroom sink faucets had heavy build up of lime scale.	21665	Corrected	9/1/17

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21665	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 toilet. Room 135: the bathroom wall had two holes through the sheet rock the diameter of a pencil. On 7/19/17, at 12:22 p.m. the ED verified the	21665		

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21665	Continued From page 20 findings and confirmed the maintenance department was unaware of the aforementioned repair needs. Following review of the maintenance scheduled assignments, the ED verified the areas were not scheduled for repair. The ED stated the facility had a plan in place to identify and repair facility maintenance and house keeping problems, however, staff may have overlooked the identified repair needs as it becomes common place when working in the same environment daily. The ED stated a quarterly audit of the entire facility was scheduled for the end of the month and he believed these problems and more would have been identified at that time. The facility policy titled Preventive Maintenance Program, revised 11/16, indicated the purpose was to provide the facility with quality, uninterrupted maintenance service 24 hours a day. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		