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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: TV99

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 **07/27/2018** (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, Unit Supervisor 07/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/31/2018 (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
07/26/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245382

July 31, 2018

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.

Effective July 23, 2018 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2018

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

RE: Project Number S5382027

Dear Mr. Hughes:

On June 21, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 23, 2018. 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 July 27, 2018, 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 May 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 23, 2018, effective July 23, 2018 and therefore remedies outlined in our letter to you dated June 21, 2018, 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: TV99

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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 **05/23/2018** (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:
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): (L15)

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

17. SURVEYOR SIGNATURE Date:
Christina Martinson, HFE NE II 07/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/25/2018 (L20)

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

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

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3. Both of the Above :
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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
June 21, 2018

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

RE: Project Number S5382027

Dear Mr. Hughes:

On May 23, 2018, 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 attached 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**

Informal Dispute Resolution - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” 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 July 2, 2018, 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 July 2, 2018 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 August 23, 2018 (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 November 23, 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245382	A. BUILDING _____ B. WING _____	05/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/20/18, through 5/23/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 5/20/18, through 5/23/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 565 SS=C	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565		7/23/18

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

Electronically Signed | 06/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	05/23/2018

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 565	Continued From page 1 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to take prompt action to resolve grievances from resident council for 9 of 9 residents (R9, R12, R20, R22, R30, R33, R38, R39 and R48) with concerns of cold food. This deficient practice had the potential to affect all 49 residents currently served food from the main kitchen of the facility.	F 565	The facility will provide education to department leaders regarding updates to the resident council policy and procedure. The education was completed on June 27, 2018 to discuss the new process and expectations of department leaders. A resident council meeting was held on June 11, 2018. Regarding the 9 residents who were affected by the cold food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	05/23/2018

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 565	Continued From page 2 Findings include: On 5/21/18, at 1:42 p.m. a resident council meeting was held and the following residents attended the meeting R9, R12, R20, R22, R30, R33, R38, R39 and R48. During the meeting the following concerns were voiced: -Residents voiced concerns about food being barely luke warm or cold, indicated they would send the cold food back to the kitchen, would be reheated and indicated the food was not very appetizing then. The residents indicated the food was usually cold a few times a week and mostly on the evening shift. The residents also indicated they thought it was a particular cook and have let the dietary manager (DM) know this. The residents further indicated the facility was short staff in the kitchen lately and believed this was part of the problem. The residents also indicated the DM stated she was working on the food being cold but it continued to be a concern. Review of Resident Council Minutes from 11/14/17 to 5/15/18, revealed the following: -on 11/14/17, residents voiced concerns of running out of food at meal times, food warm, meat tough and meals not starting on time. -on 1/18, no resident council meeting. -on 2/5/18, residents voiced concerns of food being cold. -on 3/13/18, residents voiced concerns of food being cold such as roast beef, mashed potatoes and soups. The residents indicated staff were forgetting what they requested on the menus and	F 565	concern were documented on the Resident Council Action form and will be followed up at the next council meeting. The plan to correct the cold food concern will be dietary staff interviewing residents during meal time to determine if this problem has been resolved and to offer alternatives at the time of the meal. Food temps will continue to be monitored each meal by dietary staff. Information gathered at these interviews will be documented and included in QA/PI audits. Identified trends and processes or ongoing concerns will be addressed. The resident council action form has been updated to determine if the action taken to resolve the complaint/concern satisfies the resident council or if continued revision is necessary. The Activity Director will conduct quality assurance audits to monitor and ensure effectiveness of these changes. Results will be brought forward to the QA/PI committee monthly for three months and then quarterly thereafter. Completion date July 23, 2018	

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F 565	Continued From page 3 indicated this happened during the supper meal. -on 4/24/18, residents voiced concerns with dietary, concerns were not listed. On 5/21/18, at 10:19 a.m. review of facility Resident Council Action Forms forms from 11/17 to 5/18 revealed the following: -11/14/17, a Council Action Form was filled out for running out of food at meal times, meals not being hot only warm, meat was tough for residents with dentures, meal times starting late. The form was given to the DM and indicated the form should be returned to the council by 11/28/17. The form under response indicated the facility was trying different methods for preparing meat so it wasn't tough, education to staff to increase the amount of food being prepared, ensuring food was hot and having plate warmers on so food stays hot. The form also indicated the facility was investigating meal serving start times. -3/19/18, a Council Action Form was filled out for food not being hot and staff needing to follow the menu cards more closely. The form was given to the DM and indicated the form should be returned to the council by 3/23/18. The form under response indicated the DM was going to have three residents keep a log of when food was luke warm and to point out if it was a certain meal, staff, or equipment failure. The facility provided education to give food as ordered on the menu slips and according to their diets. After Further review, two out of the three resident did not keep a log of the food concerns. R42 completed her log and the following concerns were noted:	F 565		

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- 3/18/18, chicken and mashed potatoes could have been warmer.
- 3/20/18, garlic bread raw and not baked enough.
- 3/25/18, veggies were cold and no one ate them.
- 3/27/18, complaints of hash brown casserole.
- 3/28/18, burned potatoes, was dry and no good.
- 3/29/18, poor squash, soup, beans and goulash could of been warmer.
- 3/31/18, barbequed chicken burned pretty well with hard crust on it and residents did not eat it.
- 4/2/18, veal and garlic bread not good at all.
- 4/12/18, waffle fries were terrible.
- 4/16/18, not good, soup was thick and tuna casserole dry.

No further action forms were available for review.

On 5/21/18, at 2:02 p.m. activity director (AD)-A confirmed she usually held the resident council meetings. The AD-A confirmed she had received several complaints about the food being cold at the food council meetings, filled out an action form and forwarded the form to the DM for further review.

On 5/21/18, at 2:18 p.m. DM confirmed she was aware of the resident complaints of cold food and other concerns. The DM indicated she was having her staff temp the food and was never under 135 degrees Fahrenheit. The DM indicated dietary staff was supposed to be going out and asking the residents if their food was ok and if not she expected staff to warm the food up or serve new food. The DM indicated she had R42 give feed back on the food in the building and had educated her staff on the concerns with food

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F 565	Continued From page 5 being cold. The DM confirmed she was short staffed in the kitchen and had nursing aids helping out in kitchen during these times. The DM indicated she thought the problem might be with one particular cook and thought the problem with cold food was mostly during the supper meal. The DM also indicated staff were not turning on the steam wells during meal service, which could of been part of the problem as well. The DM indicated she was aware of the continued food concerns regarding the residents complaints. Review of facility policy titled, Grievances revised on 11/16, indicated the facility was to provide residents, families and staff information on how and whom they may report concerns, incidents, and grievances without fear of retribution and provide feedback regarding the concerns that have been expressed. The facility would make prompt effort to resolve grievances. Review of facility policy titled, Resident Council, revised 6/10, indicated the purpose of the council was to suggest improvements to better the facility and services provided for the residents and families.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		7/23/18

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F 580	Continued From page 6 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 7 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to notify the physician for oxygen therapy needs for 1 of 1 residents (R13) who utilized oxygen therapy routinely. Findings include; R13's significant change Minimum Data Set (MDS) dated 3/8/18, identified R13 had diagnoses which included hypertension, atherosclerosis (hardening of arteries) of coronary artery bypass grafts without angina pectoris (chest pain) and anemia. The MDS further identified R13 was cognitively intact and required extensive assistance with dressing, bed mobility, transfers and toileting. R13 required limited assistance with walking in corridor, and supervision walking in room. R13's MDS did not identify the use of oxygen therapy. R13's care area assessments dated 3/14/18, revealed no indication of oxygen use. R13's care plan, last reviewed 5/7/18, lacked identification of oxygen use, resident goals or staff interventions. On 5/20/18, at 3:27 p.m. R13 was observed seated in her cushioned chair in her room. Next to the foot of her bed was an oxygen concentrator (medical equipment to administer oxygen). A nasal cannula (used to administer oxygen through the nose) attached to a tubing coiled on top of the concentrator which was attached to a clear plastic container (bubbler) with 1/3 water noted in it. There was a tube attached to the bubbler and the concentrator. R13 indicated it	F 580	The facility will notify the physician of changes in resident□s conditions, including the use of oxygen. The physician was notified of R13□s prn use of oxygen on 5-22-18. An order was obtained from the provider for Oxygen 2L/min via nasal cannula at bedtime and Check oxygen saturation every shift was received 5-24-18. Orders for all residents using oxygen have been reviewed to ensure compliance. Education and competency of nursing staff regarding notification of changes in resident□s health conditions, use of standing orders, and use of oxygen, including needed assessment and indications of need for oxygen was completed 6-28-18. Quality Assurance audits related to notification of resident□s health changes and use of oxygen will be completed monthly. Root Cause Analysis of noted problems and system failures will be completed and modification of processes and ongoing education will be completed as needed based on audit results. This information will be included in all scheduled quality assurance meetings of the care center for the next year to ensure ongoing compliance. Completion date July 23, 2018.	

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was her oxygen. R13 indicated she used oxygen at night. She was unable to determine how long, but indicated it had been for a long time.

On 5/21/18, at 3:55 p.m. R13 was seated in her cushioned chair, covered with a blanket. R13 did not have oxygen on at that time. R13's oxygen concentrator was at the foot of her bed with nasal cannula and tubing coiled on top.

On 5/22/18, at 7:15 a.m. nursing assistant (NA)-B was in R13's room. NA-B placed her right hand on R13's back and assisted R13 to sit in her chair. NA-B asked R13 if she wanted her oxygen on and R13 replied no. NA-B indicated R13 used oxygen PRN (as needed). NA-B indicated she had not gotten R13 up that morning, so was unsure if she had oxygen on during the night. R13 indicated she had used oxygen last night.

Review of R13's progress notes from 3/1/18, to 5/22/18, included the following:

-3/31/18, note identified R13 had complained of shortness of breath. Oxygen was administered at 2 liters per nasal cannula for comfort and anxiety.

-5/9/18, an activity note indicated R13 became short of breath being transported to an activity so a wheelchair was used. R13 was returned to her room after the activity and oxygen was applied.

R13's TARs were reviewed 3/1/18 to 5/22/18, and lacked orders for oxygen therapy.

R13's current physician orders signed 2/14/18, lacked orders for oxygen therapy.

R13's Madison Healthcare Services hospital

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discharge orders dated 4/5/18, lacked orders for oxygen therapy.

R13's Madison Health Care Center Standing orders, signed 9/25/15, included an order for oxygen at 2 L(liters)/minute via cannula, prn. In bold writing below the oxygen order it instructed "Notify Physician".

Review of R13's physician progress notes from 2/14/18, to 5/21/18, identified the following;

-4/5/18, discharge summary identified R13 was less SOB (short of breath) and chest pain improved. R13 was discharged back to facility in stable condition. Review of hospital physician progress notes indicated oxygen was used per nasal cannula at the hospital. The documentation lacked indication of oxygen therapy to be used at the facility.

-4/12/18, hospital follow up physican visit indicated R13 was hospitalized for hypertension, shortness of breath and chest pain. Note identified R13 continued heavy breathing and shortness of breath. Exam indicated non-labored breathing, able to speak full sentences without needing to stop for breath, respiratory rates increased, but slowed down after a moment and lungs clear. Note identified suspect severe pulmonary hypertension was contributing to patient's heavy breathing. Question if she'd benefit from prn supplemental oxygen to reduce that sensation. Documentation lacked orders for oxygen therapy.

Review of R13's oxygen saturation levels from 8/5/17, to 5/19/18, identified R13's oxygen saturation was documented within ranges of 94%

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to 99% on room air. On 5/12/18, at 10:55 a.m. it was documented R13's saturation was 97% with oxygen via nasal cannula.

On 5/22/18, at 8:25 a.m. during a group interview, licensed practical nurse (LPN)-A, indicated R13 used oxygen at night and PRN. LPN-A checked R13's Treatment Administration Record (TAR) and could not locate orders for oxygen usage. Assistant director of nursing (ADON)-A also reviewed R13's medical record and could not find orders for oxygen usage. ADON indicated oxygen orders were on the facility standing orders. ADON indicated she would review R13's medical record for more information.

On 5/22/18, at 9:26 a.m. clinical manager (CM)-A indicated she was not aware if R13 had oxygen orders, and indicated she was new to her position at the facility. CM-A indicated she was aware that oxygen was on the facility standing orders and indicated her usual process when initiating oxygen use from a standing order was to notify the physician. If oxygen was then ordered, she would add the order to the TAR.

On 5/22/18, at 10:58 a.m. NA-C indicated she often cared for R13. NA-C stated R13 had her oxygen on that morning and used it every night. NA-C indicated R13 sometimes would get "worked up" and they would give her oxygen during the day and it calmed her down and indicated R13 had used oxygen for more than a year. NA-C indicated she always wore oxygen at night and used it during the day 2-3 times per week. NA-C indicated R13 would get short of breath until staff entered her room. She said she would put R13's oxygen on, then leave the room,

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stand outside R13's room, and then NA-C could hear her calm down and breath normally again.

On 5/22/18, at 11:48 a.m. LPN-A indicated she worked the day shift and R13's oxygen was usually removed between 5:00 a.m. and 5:30 a.m. LPN-A indicated she had only given R13 oxygen one time in the past few weeks and stated she was not sure how long R13 had been using oxygen but indicated it was around a year.

On 5/22/18, at 10:48 a.m ADON-A indicated she went to the clinic and spoke to R13's primary physician (PA)-A to discuss R13's oxygen use. ADON indicated PA-A told her she thought she wrote an order or would have written an order for R13 to receive oxygen.

On 5/22/18, at 11:36 a.m. a phone interview was conducted with R13's PA-A. PA-A indicated R13 had diastolic CHF (congestive heart failure) PA-A indicated R13's shortness of breath was mostly related to her stricture of her esophagus. She indicated R13 recently had dilation (stretching) of her esophagus. PA-A confirmed she had seen her yesterday regarding her ear and hearing and stated indicated she also adjusted R13's blood pressure medications at that time. PA-A indicated she would expect staff to notify her if they were using oxygen for R13 and stated ADON had told her that day that R13 was using oxygen, but she was unaware she was using it longer. PA-A indicated she would expect nursing staff to notify her when they began oxygen use and get an order and indicated the nursing staff should also be monitoring R13.

On 5/23/18, at 12:27 p.m. DON indicated if nursing staff started oxygen using the standing

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F 580	Continued From page 12 orders, she would expect them to notify the physician. DON confirmed it was written in bold letters on the standing orders for the physician to be notified. DON indicated it would only be used at 2 liters per minute as written on the standing orders. DON indicated she was not aware R13 had used oxygen PRN during the day and felt she had not received it for a year. DON indicated she was aware R13 had oxygen therapy, but thought she had a current order. DON and surveyor reviewed R13's current orders and the primary physician documentation from 4/12/18, which indicated R13 may benefit from PRN oxygen use. DON confirmed R13 did not have an order, assessment or monitoring and the physician documentation from 4/12/18, was not an actual order. The facility policy titled Standing Orders, reviewed 5/17, identified the orders were approved by the medical director, reviewed annually and ordered by the resident's primary physician.	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		7/23/18

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and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 15 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) Ombudsman of a facility initiated transfer for 1 of 1 resident (R4) who was transferred to an acute care facility on an emergency basis. Findings include: R4's annual Minimum Data Set (MDS) dated 5/11/18, identified R4 was severely cognitively impaired and had diagnoses which included dementia, chronic obstructive pulmonary disease (COPD) and macular degeneration. The MDS indicated R4 required extensive assistance with activities of daily living (ADLs). Review of R4's progress notes from 5/1/18 to 5/22/18, revealed: -5/3/18, nursing staff heard a "very loud Klunk/thump then followed with very loud crying out (ow, ow)" [SIC]. R4 had fallen and hit their head and was sent to the Emergency Room. R4 returned from the hospital after negative x-rays and CT scan were clear. Review of R4's clinical record revealed a provider note from the Emergency Department dated 5/3/18, which indicated R4 was seen after a fall at the care center with a discharge diagnosis of fall and head contusion (bruise) and discharged back to care center. On 5/22/18, at 12:29 p.m. licensed practical nurse (LPN)-A stated she was the staff nurse on duty on	F 623	The facility will provide notification of transfer/discharge as required, including residents going the emergency department, within our facility, and returning to the care center without admission to another care setting. The transfer/discharge notice was faxed to the ombudsman on 5-22-18 for R4□s emergency room visit 5-3-18. This notice to the ombudsman was within the guideline provided to care centers allowing them to fax transfer/discharge notices to the ombudsman in monthly batches.It should be noted that over the past year 48 transfer/discharge notices have been faxed to the ombudsman. The transfer/discharge notice policy and procedure was reviewed, updated and approved 6-26-18. Licensed nurses and social services were educated regarding the transfer/discharge notice requirements on 6-28-18. Transfer/Discharge requirements have been added to the nurse orientation process. Quality Assurance Audits of transfer/discharge notifications will be completed weekly and results reported to the quality assurance committee at scheduled meetings for the next six months to ensure ongoing compliance. Modification of processes and ongoing education will be completed to address concerns noted. We will monitor for at least the next year, however, frequency of	

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F 623	Continued From page 16 5/3/18, when R4 fell. LPN-A stated the clinical manager (CM)-B wanted R4 to be evaluated at the emergency department (ED) due to how hard it sounded when R4 hit their head during the fall. On 5/22/18, at 12:58 p.m. assistant director of nursing (ADON) stated she was responsible for notification to the LTC Ombudsman regarding transfers and discharges. ADON stated the facility's procedure for updating the LTC Ombudsman did not include sending a notification for a resident that was transferred to an emergency department. ADON stated that once the facility was notified that the resident would be admitted or transferred to another acute care facility, then a notification would be sent to the LTC Ombudsman. On 5/22/18, at 1:15 p.m. director of nursing (DON) stated the LTC Ombudsman was updated on all transfers and discharges that were facility initiated. However, she stated she would not expect staff to update the LTC Ombudsman of a facility initiated transfer to an acute care facility on an emergency basis unless the resident did not return to the facility. On 5/22/18, at 2:04 p.m. facility administrator stated the facility was not aware of the Center for Medicare and Medicaid (CMS) memo CMS 17-25, dated May 2017, and stated the facility was now aware of the regulation and would send the LTC Ombudsman R4's notification of transfer. On 5/23/18, at 8:47 a.m. ADON stated she had sent R4's facility initiated transfer information from 5/4/18, to the LTC Ombudsman and would be continuing to send facility initiated emergency	F 623	audits and reporting may be modified after six months of monitoring, if processes are noted to be hardwired and 100% compliance has been established. Completion date July 23, 2018.	

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F 623	Continued From page 17 transfer information to the LTC Ombudsman from this day forward. A policy for notification to the LTC Ombudsman was requested but not provided.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		7/23/18

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F 625	Continued From page 18 Based on interview and document review, the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of an emergency transfer for 1 of 1 resident (R4) who was transferred to an acute care facility on an emergency basis. Findings include: R4's annual Minimum Data Set (MDS) dated 5/11/18, indicated R4 was severely cognitively impaired and had diagnoses which included dementia, chronic obstructive pulmonary disease (COPD) and macular degeneration. The MDS indicated R4 required extensive assistance with activities of daily living. Review of R4's progress notes from 5/1/18 to 5/22/18, revealed: -5/3/18, nursing staff heard a "very loud Klunk/thump then followed with very loud crying out (ow, ow)" [SIC]. R4 had fallen and hit their head and was sent to the Emergency Room. R4 returned from the hospital after negative x-rays and a CT scan was clear. Review of R4's clinical record revealed a provider note from the Emergency Department dated 5/3/18, which indicated R4 was seen after a fall at the care center with a discharge diagnosis of fall and head contusion (bruise) and discharged back to care center. On 5/22/18, at 12:29 p.m. licensed practical nurse (LPN)-A stated she was the staff nurse on duty on 5/3/18, when R4 fell. LPN-A stated the clinical manager (CM)-B wanted R4 to be evaluated at the emergency department (ED) due to how hard	F 625	Bed hold notices will be provided to all residents upon transfer to a hospital or the resident goes on therapeutic leave, including visits to the emergency room, within our facility, and there is no admission to the hospital. Education was provided to licensed nurses and social services regarding giving and documentation of the Bed hold policy on 6-28-18. The bed hold policy process has been added to nurse orientation. Quality Assurance audits of giving and documentation of the bed hold policy will be completed weekly and reported at all scheduled quality assurance meetings for the next six months to ensure ongoing compliance. Modifications of processes and ongoing education will be done as needed based on results of audits. Following the first six months of monitoring, frequency of audits may be modified, however we will continue to monitor for the next year. It should be noted 483.15(d)(2) clearly states At the time of transfer of a resident for hospitalization or therapeutic leave, an nursing facility must provide to the resident and the representative written notice which specifies the duration of the bed-hold policy. Since this resident was not hospitalized, we were unaware of the need to provide a bed hold policy and believed we were in compliance. Completion date July 23, 2018.	

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F 625	Continued From page 19	F 625		

it sounded when R4 hit their head during the fall. LPN-A stated bed holds were not provided at the time of transfer to the hospital, if the facility thought they would not be admitted. LPN-A stated if the facility was sending a resident with a suspected fracture or something serious then the facility would send a bed hold notice, or call the family and get the verbal approval for a bed hold and then have the family sign the bed hold notice at a later time. LPN-A confirmed a bed hold notice was not offered at the time of R4's transfer.

On 5/22/18, at 12:50 p.m. licensed social worker (LSW) stated the bed hold policy was reviewed with resident/resident representative upon admission by the LSW, and a bed hold notice would be given at the time of transfer out of the facility, including a transfer to the emergency room.

On 5/22/18, at 1:15 p.m. director of nursing (DON) stated bed hold notification was given any time a resident was transferred or discharged from the facility, or was going out overnight on a pass. She stated she would not expect a bed hold notice to be given to a resident or resident representative if the resident was sent to the emergency room or admitted to the hospital on an observational status, but would expect a bed hold notice to be sent out later, if the resident was at the emergency room and was then admitted, or sent out to another hospital system.

On 5/23/18, at 8:47 a.m. assistant director of nursing (ADON) confirmed R4 did not receive a bed hold notification for the transfer on 5/3/18.

A facility policy titled Madison Healthcare Services Bed Hold Policy, last revised 11/2016, indicated

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F 625	Continued From page 20 the policy was to ensure that written information be provided to the resident or their representative before transferring to an acute care hospital or before leaving for a therapeutic leave.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate coding to rflect resident status on the Minimum Data Set (MDS) for 2 of 2 residents (R13, R4) reviewed. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/17, identified Section J: Health Conditions was to be completed with the intent to document health conditions, such as falls, that impact a resident's functional status and quality of life. The manual indicated "Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls". Further, the manual provided several assessment steps including: "Review all available sources for any fall since the last assessment... Include medical records generated in any health care setting since last assessment" and "It is important to ensure the accuracy of the level of injury resulting from a fall".	F 641	The facility will code assessments accurately. R4□s MDS and CAA for falls was modified and submitted on 5-25-18 to accurately reflect the resident□s condition. R13 MDS was not modified as there was no documentation during the assessment period within the medical record to indicate the resident was receiving oxygen. Her care plan has been updated to reflect her current oxygen use. Both of these MDS□s were completed by care coordinators who were in this position at our facility less than three months. An experienced care coordinator had been reviewing their completed MDS□s prior to submission. It is the intent and expectation that all MDS□s are coded accurately. However, when an error is noted a modification to the MDS is completed per the MDS manual. Quality assurance audits of full MDS□s will be completed monthly looking at trends of coding errors. This information	7/23/18

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F 641	Continued From page 21 R4's annual Minimum Data Set (MDS) dated 5/11/18, identified R4 was severely cognitively impaired and had diagnoses which included dementia, chronic obstructive pulmonary disease (COPD) and macular degeneration. The MDS indicated R4 required extensive assistance with activities of daily living (ADLs). R4's MDS Section J: Health Conditions, has the resident had any falls since the prior assessment was marked "yes". The number of falls since prior assessment without injury was marked as two or more falls, and the falls with injury (except major) was left unmarked. R4's Care Area Assessment (CAA) for falls dated 5/14/18, indicated R4 had a history of falls. However, R4's Falls CAA section, History of Falling, was left blank. Review of R4's progress notes from 5/1/18, to 5/22/18, revealed: -5/3/18, nursing staff heard a "very loud Klunk/thump then followed with very loud crying out (ow, ow) [SIC]." R4 had fallen and hit their head and was sent to the Emergency Room. R4 returned from the hospital after negative x-rays and CT scan were clear. Review of R4's clinical record revealed a provider note from the Emergency Department dated 5/3/18, which indicated R4 was seen after a fall at the care center with a discharge diagnosis of fall and head contusion (bruise) and discharged back to care center. On 5/22/18, at 12:29 p.m. licensed practical nurse (LPN)-A stated she was the staff nurse on duty on 5/3/18, when R4 fell. LPN-A stated the clinical	F 641	will be reported to the quality assurance committee monthly to ensure ongoing compliance. Ongoing education will be provided as needed based on audit information. Modifications of MDS□s with noted errors will continue to be completed as needed. Completion date July 23, 2018.	

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F 641	Continued From page 22 manager (CM)-B wanted R4 to be evaluated at the emergency department (ED) due to how hard it sounded when R4 hit their head during the fall. On 5/23/18, at 12:27 p.m. CM-B confirmed she completed R4's annual MDS dated 5/11/18, and stated R4 had two falls without injury during the last assessment period. CM-B confirmed R4 had a fall on 5/3/18, and was sent to the ED for assessment. CM-B stated the data collected to answer Section J, regarding falls, came from the Risk Management portion of the electronic health record. She stated she did not consider the ED progress note as a source of R4's information regarding falls. CM-B confirmed the discharge diagnosis of fall with head contusion would be a fall with injury, and R4's MDS Section J, regarding falls, should contain a fall with injury to be accurate. On 5/23/18, at 1:00 p.m. director of nursing (DON) stated she would expect the information on R4's annual MDS dated 5/11/18, to be accurate. R13's significant change MDS dated 3/8/18, identified R13 had diagnoses which included hypertension, atherosclerosis (hardening of arteries) of coronary artery bypass grafts without angina pectoris (chest pain) and anemia. The MDS further identified R13 was cognitively intact and required extensive assistance with dressing, bed mobility, transfers and toileting. R13 required limited assistance with walking in corridor, and supervision walking in room. R13's MDS section O, oxygen therapy was left open, which indicated	F 641		

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F 641	Continued From page 23	F 641		

no oxygen therapy.

R13's care area assessments (CAAs) dated 3/14/18, revealed no indication of oxygen use.

On 5/20/18, at 3:27 p.m. R13 was observed sitting in her cushioned chair in her room. Next to the foot of her bed was an oxygen concentrator (medical equipment to administer oxygen). There was a nasal cannula (used to administer oxygen through the nose) attached to a tubing coiled on top of the concentrator that was attached to a clear plastic container (bubbler) with 1/3 water noted in it. There was a tube attached to the bubbler and the concentrator. R13 indicated it was her oxygen. R13 indicated she used oxygen at night. She was unable to determine how long, but indicated it was a long time.

On 5/21/18, at 3:55 p.m. R13 was sitting in her cushioned chair, covered with a blanket, her feet were on the floor. R13' did not have oxygen on at that time. R13's oxygen concentrator was at the foot of her bed, with nasal cannula and tubing coiled on top.

On 5/22/18, at 7:15 a.m. nursing assistant (NA)-B was in R13's room. NA-B placed her right hand on R13's back and assisted R13 to sit in her chair. NA-B asked R13 if she wanted her oxygen on and R13 replied no. NA-B indicated R13 used oxygen PRN (as needed). NA-B indicated she had not gotten R13 up that morning, so was unsure if she had oxygen on during the night. R13 indicated she had used oxygen last night.

On 5/22/18, at 10:58 a.m. NA-C indicated she often cared for R13. NA-C indicated R13 had her oxygen on that morning and used it every night.

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F 641	Continued From page 24 NA-C indicated R13 sometimes would get "worked up" and they would give her oxygen during the day and it calmed her down. NA-C indicated R13 had used oxygen for more than a year. NA-C indicated she always wore oxygen at night and used it during the day 2-3 times per week. NA-C indicated the nurses set the oxygen rate and it would be on R13's TAR. She indicated she was not sure of the rate, but thought R13's oxygen was set at 3 or maybe 2 liters per minute. NA-C indicated R13 would get short of breath until staff entered her room. She said she would put R13's oxygen on, then leave the room, stand outside R13's room, and then NA-C could hear her calm down and breath normally again. On 5/22/18, at 11:48 a.m. LPN-A indicated she worked the day shift, and R13's oxygen was usually removed between 5:00 a.m. and 5:30 a.m. LPN-A indicated she had only given R13 oxygen one time in the past few weeks. LPN-A indicated she was not sure how long R13 had been using oxygen but indicated it was around a year. On 5/23/18, at 12:27 p.m. the director of nursing (DON) indicated she was aware R13 utilized oxygen therapy, and thought she had a current order. A facility policy for MDS was requested, however the DON stated the facility did not have a specific policy on MDS, and the facility staff followed the RAI manual.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		7/23/18

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F 689	Continued From page 25 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R100) who utilized a walker for ambulation. Findings include: R100's Diagnosis Report listed diagnoses which included dementia without behavorial disturbances, repeated falls, and dizziness and giddiness. R100's Safety Risk Assessment dated 5/14/18, indicated R100 had history of falls, decline in functional status, required assistance, had impaired hearing/vision and forgot to lock brakes on four wheeled walker. R100's care plan revised on 5/20/18, identified R100 a moderate risk for falls related to gait/balance problems, unaware of safety needs and vision/hearing problems. The care plan listed various interventions which included: R100 needed a safe environment with even floors free from spills, clutter, adequate and glare free light, working and reachable call light, bed in low position at night, personal items within reach, used a four wheeled walker and staff to ensure that R100 had walker within reach when in bed or	F 689	The facility will provide freedom from hazards, supervision and use devices, including seated walkers, in a manner which ensures safety for our residents. R100 was discharged 5-31-2018. Residents who currently use seated walkers have been educated on the safe use of the walker. New residents with seated walkers will be educated on safe use of the walker. Staff education for safe patient handling was completed 5-24 & 31-2018. This education included safe use of seated walkers. Education on the safe use of seated walkers was also included in the nursing staff meeting 6-28-18. Ongoing staff and resident observation and education will be done regarding safety as needed. Use of seated walkers will also be included in new employee orientation. Quality assurance audits of risk management incidents related will be completed monthly and reported to the quality assurance committee to ensure ongoing compliance. Completion date July 23, 2018.	

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recliner.

R 100's current signed orders from physical therapy on 5/11/18 indicated patient evaluation completed. Patient requires assist of one with four wheeled walker for all transfers. Will plan to see patient two times a week to work on balance, strength, safety awareness, ambulation impairments, unsteadiness on feet and generalized weakness.

During observations on 5/22/18, at 7:32 a.m. R100 was seated in his recliner in his room with a black four wheeled walker sitting in front of him with nursing assistant (NA)-A present. R100 proceeded to unlock the brakes on his walker, stood up independently and began to ambulate out of his room with NA-A by his side. R100 walked independently down the hallway towards the dining room.

-at 7:34 a.m. R100 stopped, turned around and sat down on the seat of his walker. NA-A asked R100 if he wanted a wheel chair and he replied no. NA-A began to push R100 backwards while he was seated on the walker, down the hallway to the dining room while R100 raised his feet. NA-A pushed R100 approximately 114 feet from the hallway to the dining room table.

-at 7:35 a.m. R100 independently transferred from his walker to the dining room chair. R100's walker had a manufactures warning label on the middle cross bar of the walker that stated "this is a walker aid only and was not to be used as a transportation device."

On 5/22/18, at 10:46 a.m. NA-A confirmed R100 needed stand by assistance of staff with

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ambulation, transfers and utilized a walker. NA-A verified she had transported R100 while utilizing the bench of his walker and indicated R100 had never done this before and stated usually he would walk the entire length of the hallway and down to the dining room. NA-A stated she was surprised R100 sat down on his walker. NA-A indicated R100 did not like to use his wheel chair and would refuse it. NA-A indicated she normally would not transport residents like this due to safety reasons of the walker tipping forward.

On 5/22/18, at 12:03 p.m. assistant director of nursing (ADON) confirmed R100 needed stand by assistance of staff with ambulation, transfers and utilized a four wheeled walker. The ADON also verified the manufactures warning label on R100's walker and indicated staff should not be transporting residents backwards on a walkers due to safety reasons.

On 5/22/18, at 12:32 p.m. physical therapist (PT) confirmed R100 was currently seeing therapy and needed assistance of staff with ambulation and utilized a four wheeled walker. The PT indicated R100 was to use the seat of his walker if he got tired and needed to rest during ambulation. The PT indicated the walker was not a mode of transportation and staff should not be pushing R100 on the walker. The PT verified this was a safety issue due to the potential for tipping while using it to transport the resident and indicated this was not safe. The PT indicated she would rather staff let R100 sit on his walker, let him rest and continue to let him walk.

On 5/22/18, at 1:30 p.m. director of nursing (DON) confirmed R100 needed stand by assistance of staff with ambulation, transfers and

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F 689	Continued From page 28 utilized a walker. The DON verified R100's current care plan and indicated staff should be following the care plan as written. The DON indicated staff should not be utilizing R100's walker as a mode of transportation due to safety reasons. The DON indicated staff should not be pushing R100 backwards on his walker and stated "it was not safe." The DON verified staff had just received training from PT on how to use R100's walker with ambulation and transfers. The DON indicated she would expect staff to utilize R100's wheel chair instead of his walker for transportation if needed. Review of facilty policy titled, Walker dated 5/17, indicated all resident will be assessed upon admission and as needed for their ability to ambulate. An ambulation program will be developed based on the individual needs and will be included in the care plan. Review of manufacturers guidelines titled, Four Wheeled Walker dated 2006, indicated the walker was not intended to be used as a wheel chair. do not move the walker when sitting in it. Review of user Guide titled, Ultra Light Rollator revised on 7/1/08, under safety instructions indicated Rollator's are for individual use only and ar not to be used as wheel chair, do not attempt to put the Rollator while someone is sitting on the seat and do not self propel the Rollator while seated. Serious injury to the user and /or damage to the Rollator walker frame or wheels may result from improper use.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		7/23/18

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F 695	Continued From page 29 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately assess respiratory status, and provide ongoing monitoring and equipment maintenance for 1 of 1 residents (R13) who utilized oxygen therapy. Findings include; R13's significant change Minimum Data Set (MDS) dated 3/8/18, identified R13 had diagnoses which included hypertension, atherosclerosis (hardening of arteries) of coronary artery bypass grafts without angina pectoris (chest pain) and anemia. The MDS further identified R13 was cognitively intact and required extensive assistance with dressing, bed mobility, transfers and toileting. R13 required limited assistance with walking in corridor, and supervision walking in room. R13's MDS also indicated no oxygen therapy. R13's care area assessments (CAAs) dated 3/14/18, revealed no indication of oxygen use. R13's care plan, last reviewed 5/7/18, lacked identification of oxygen use, resident goals or staff interventions. On 5/20/18, at 3:27 p.m. R13 was observed	F 695	Residents receiving respiratory care, including oxygen administration, will have this care provided in a consistent professional manner, including assessment and care planning. R13 currently has an order for oxygen, is assessed for oxygen need and oxygen use has been care planned. The facility will notify the physician of changes in resident□s conditions, including the use of oxygen. The physician was notified of R13□s prn use of oxygen on 5-22-18. An order was obtained from the provider for Oxygen 2L/min via nasal cannula at bedtime and Check oxygen saturation every shift was received 5-24-18. Orders for all residents using oxygen have been reviewed to ensure compliance. Education and competency of nursing staff regarding notification of changes in resident□s health conditions, use of standing orders, and use of oxygen, including needed assessment and indications of need for oxygen was completed 6-28-18. Quality Assurance audits related to notification of resident□s health changes	

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F 695	Continued From page 30 sitting in her cushioned chair in her room. Next to the foot of her bed was an oxygen concentrator (medical equipment to administer oxygen). There was a nasal cannula (used to administer oxygen through the nose) attached to a tubing coiled on top of the concentrator that was attached to a clear plastic container (bubbler) with 1/3 water noted in it. There was a tube attached to the bubbler and the concentrator. R13 indicated it was her oxygen. R13 indicated she used oxygen at night. She was unable to determine how long, but indicated it was a long time. The tubing lacked labeling or markings on the tubing. On 5/21/18, at 3:55 p.m. R13 was seated in her cushioned chair, covered with a blanket, with her feet were on the floor. R13' did not have oxygen on at that time. R13's oxygen concentrator was at the foot of her bed, with nasal cannula and tubing coiled on top. On 5/22/18, at 7:15 a.m. nursing assistant (NA)-B was in R13's room. NA-B placed her right hand on R13's back and assisted R13 to sit in her chair. NA-B asked R13 if she wanted her oxygen on and R13 replied no. NA-B indicated R13 used oxygen PRN (as needed). NA-B indicated she had not gotten R13 up that morning, so was unsure if she had oxygen on during the night. R13 indicated she had used oxygen last night. Review of R13's progress notes from 3/1/18, to 5/22/18, included the following: -3/31/18, note identified R13 had complained of shortness of breath. Oxygen was administered at 2 liters per nasal cannula for comfort and anxiety. -5/9/18, an activity note indicated R13 became	F 695	and use of oxygen will be completed monthly. Root Cause Analysis of noted problems and system failures will be completed and modification of processes and ongoing education will be completed as needed based on audit results. This information will be included in all scheduled quality assurance meetings of the care center for the next year to ensure ongoing compliance. Completion date July 23, 2018.	

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short of breath being transported to an activity so a wheelchair was used. R13 was returned to her room after the activity and oxygen was applied.

R13's TARs were reviewed 3/1/18, to 5/22/18 and lacked orders for oxygen therapy.

R13's current physician orders signed 2/14/18, lacked orders for oxygen therapy.

R13's Madison Healthcare Services hospital discharge orders dated 4/5/18, lacked orders for oxygen therapy.

R13's Madison Health Care Center Standing orders, signed 9/25/15, included an order for oxygen at 2 L(liters)/minute via cannula, prn. In bold writing below the oxygen order it instructed "Notify Physician".

Review of R13's physician progress notes from 2/14/18, to 5/21/18, identified the following;

-2/14/18, physician nursing home visit progress note lacked orders or documention of oxygen therapy use.

-2/28/18, primary physician progress note lacked documentation of oxygen therapy.

-4/5/18, discharge summary identified R13 was less SOB (short of breath) and chest pain improved. R13 was discharged back to facility in stable condition. Review of hospital physician progress notes indicated oxygen was used per nasal cannula at the hospital. The documentation lacked indication of oxygen therapy to be used at the facility.

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-4/12/18, hospital follow up physican visit indicated R13 was hospitalized for hypertension, shortness of breath and chest pain. Note identified R13 indicated continued heavy breathing and shortness of breath. Exam indicated non-labored breathing, able to speak full sentences without needing to stop for breath, respiratory rates increased, but slowed down after a moment and lungs clear. Note identified suspect severe pulmonary hypertension was contributing to patient's heavy breathing. Question if she'd benefit from prn supplemental oxygen to reduce that sensation. Documentation lacked orders for oxygen therapy.

-4/26/18, primary physician clinic visit note lacked documention of oxygen use.

-5/3/18, physician note lacked documentation of oxygen use.

-5/15/18, history and physical, identified R13 indicated trouble with shortness of breath walking up a slight hill. The documentation further identified shortness of breath when anxious. The note lacked documention of current oxygen therapy.

-5/21/18, clinic visit with primary physician. The note lacked documention regarding oxygen therapy.

Review of R13's oxygen sats from 8/5/17, to 5/19/18, identified R13's oxygen saturation was documented within ranges of 94% to 99% on room air. On 5/12/18, at 10:55 a.m. it was documented R13's saturation was 97% with oxygen via nasal cannula.

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Review of R13's medical record lacked a documentation of a comprehensive respiratory assessment for oxygen therapy.

On 5/22/18, at 8:25 a.m. licensed practical nurse (LPN)-A, indicated R13 used oxygen at night and PRN. LPN-A indicated the usual facility process was for night staff to change oxygen tubing, and thought it was once every week. She indicated the facility utilized stickers to write on and attach to the new tubing when they changed the tubing. LPN-A and surveyor checked R13's oxygen tubing. No stickers were attached, but a small date 5/2/18, difficult to read, was written with black marker on the tubing. LPN-A checked R13's Treatment Administration Record (TAR) and could not locate orders for oxygen usage or tubing changing.

On 5/22/18, at 9:26 a.m. clinical manager (CM)-A indicated she was not aware if R13 had oxygen orders, and indicated she was new to her position at the facility. CM-A indicated she was aware that oxygen was on the facility standing orders. CM-A indicated her usual process when initiating oxygen use from a standing order was to notify the physician. If oxygen was ordered she would add the order to the TAR. CM-A indicated she would initiate monitoring for shortness of breath, oxygen sats (oxygen saturation of hemoglobin in the blood) and oxygen use. CM-A indicated oxygen tubing was changed every 2 weeks. CM-A indicated R13's tubing needed to be changed. At 9:59 a.m. CM-A indicated if R13 was using oxygen, she would expect it to be documented on R13's MDS.

On 5/22/18, at 10:58 a.m. NA-C indicated she often cared for R13. NA-C indicated R13 had her

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oxygen on that morning and used it every night. NA-C indicated R13 sometimes would get "worked up" and they would give her oxygen during the day and it calmed her down. NA-C indicated R13 had used oxygen for more than a year. NA-C indicated she always wore oxygen at night and used it during the day 2-3 times per week. NA-C indicated R13 would get short of breath at times until staff entered her room. She was not sure if the oxygen was order was for 2 liter or 3 liters. She stated she would apply R13's oxygen, then leave the room, stand outside R13's room, and then NA-C could hear her calm down and breath normally again.

On 5/22/18, at 11:48 a.m. LPN-A indicated she worked the day shift, and R13's oxygen was usually removed between 5:00 a.m. and 5:30 a.m. LPN-A indicated she had only given R13 oxygen one time in the past few weeks. LPN-A indicated she was not sure how long R13 had been using oxygen but indicated it was around a year.

On 5/22/18, at 10:48 a.m director of nursing (DON) and ADON-A reviewed the facility process for changing oxygen tubing with surveyor. ADON indicated she was not sure, but thought R13's tubing was changed on 5/20/18. She indicated the usual facility process was to write the date the oxygen tubing was changed on a label, then attach the label to the new tubing.

On 5/22/18, at 11:36 a.m. a phone interview was conducted with R13's PA-A. PA-A indicated R13 had diastolic CHF (congestive heart failure) PA-A indicated R13's shortness of breath was mostly related to her stricture of her esophagus. PA-A indicated she would expect staff to notify her if

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they were using oxygen for R13. PA-A indicated she was unaware R13 utilized oxygen long term in the facility. PA-A indicated she would expect them to check her oxygen sats. If they were normal R13 would not need oxygen. PA-A indicated she would expect nursing staff to notify her when they began oxygen use and get an order. PA-A indicated the nursing staff should also be monitoring R13.

On 5/23/18, at 12:27 p.m. DON indicated if nursing staff started oxygen using the standing orders, she would expect them to notify the physician. DON confirmed it was written in bold letters on the standing orders for the physician to be notified. DON indicated R13's oxygen would only be used at 2 liters per minute as written on the standing orders. DON indicated she was not aware R13 had used oxygen PRN during the day and felt she had not received it for a year. DON indicated she was aware R13 had oxygen therapy, but thought she had a current order. DON indicated she would expect a respiratory assessment to be completed, monitoring and R13's oxygen tubing changed routinely. DON indicated nursing staff indicated R13's tubing had been changed on 5/20/18, but stated documentation of routine change of the tubing was not documented. DON indicated the nurses set oxygen dosage, but certified nursing assistants and activity staff were trained by her to apply it to the resident and turn the oxygen concentrator on and off. DON and surveyor reviewed R13's current orders and the primary physician documentation from 4/12/18, which indicated R13 may benefit from PRN oxygen use. DON confirmed R13 did not have an order, assessment or monitoring of R13's oxygen use. She stated the physician documentation from

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F 695	Continued From page 36 4/12/18, was not an actual order but a possible consideration in the future. The facility policy titled Standing Orders, reviewed 5/17, identified the orders were approved by the medical director, reviewed annually and ordered by the resident's primary physician. The facilty policy titled Oxygen (O2) reviewed 6/17, identified the purpose was to safely administer and maintain the process of oxygen administration. The policy further identified upon a physician's orders, a LPN or RN (registered nurse) would administer oxygen. The procedure refers to Lippincott's Nursing Procedure Book (6th edition) pages 537-542 for instructions. The procedure book includes instructions to verify the physician's orders for oxygen therapy. The manual further instructed an assessment to be completed including vital signs, lung sounds, oxygen saturation and physical assessment then monitoring of the oxygen therapy. Finally the pages listed identified documentation should include date and time oxygen administered, type of delivery, flow rate, vitals, skin color, respiratory effect, lung sounds and response before and after administration and resident teaching.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		7/23/18

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F 757	Continued From page 37 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain physician ordered FT4 (a blood test to evaluate thyroid function) for 1 of 1 residents (R28) who received a routine dose of Levothyroxine (thyroid stimulating hormone (TSH) medication) . Findings include: Review of R28's signed physician orders dated 4/19/18, identified R28 had a diagnosis of hypothyroidism and received the TSH medication Levothyroxine 25 mcg (micrograms) every day, with a start date of 11/27/18. During review of the medical record a verbal / telephone order dated 2/16/18, was found. The order directed laboratory blood draw for a TSH and FT4. A TSH laboratory (lab) draw had been completed; however, a FT4 was not found in the record. On 5/21/18, at 3:09 p.m. licensed practical	F 757	Residents will be free from unnecessary medications. R28 had a T4 completed 5-22-18. Results showed ongoing need for treatment of hypothyroidism and no changes were made to her synthroid medication order. It should be noted that a TSH, done as ordered on 2-16-2018, also indicated the ongoing need for synthroid to treat her diagnosis of hypothyroidism. Standard of practice for a resident with a diagnosis of hypothyroidism, is to start a medication like synthroid to treat the diagnosis hypothyroidism. The provider would schedule lab work to monitor effectiveness of that medication. Typically, the only test required to justify need for a thyroid medication, such as synthroid, would be a TSH level, not a T4. The process for laboratory test was reviewed and revised, with the cooperation of laboratory staff, clinic staff, care center staff and medical director on	

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F 757	Continued From page 38 (LPN)-B verified she had faxed the order for the TSH and FT4 to the lab. LPN-B phoned the lab to request results of the FT4. LPN-B verified a FT4 had not been drawn for R28. On 5/21/18, at 3:15 p.m. the lab returned a call to LPN-B and identified a lab technician would come to the facility in the morning and draw the FT4. A written order dated 5/21/18, at 3:36 p.m. was received by the facility to complete the lab draw for FT4. On 5/22/18, at 9:13 a.m. LPN-A identified all lab draws were placed on the calendar by the director of nursing (DON) or the assistant director of nursing (ADON) and the day shift nurse was responsible to follow up on the results. On 5/22/18, at 11:21 a.m. the ADON verified lab orders were scheduled on a calendar. After review of the calendar on unit 1, the ADON verified the lab had not been written on the calendar. With review of the initial order form dated 2/16/18, the ADON indicated the form was filled out incorrectly by the nurse who received the telephone order. The ADON indicated an X should have been placed in the box in front of the ordered labs rather than written out. The ADON verified a new order was received and the lab had been completed. On 5/23/18, at 10:20 a.m. the DON indicated the process for completing physician ordered laboratory blood draws included passing the task to numerous others which complicated the process. The DON indicated the facility needed a better system as the system currently in place had too many steps to complete the task. The	F 757	June 4, 2018. Education for licensed nurses regarding the laboratory process was done 6-28-18. The consulting pharmacist was informed of this concern 6-6-2018 and is assisting with monitoring for unnecessary medications and needed laboratory tests. Quality assurance audits of laboratory requests and results are being completed weekly. Root Cause Analysis of identified system failures will be completed and process changes made as needed. Results of audits will be reported to the quality assurance committee during scheduled care center QA/PI meetings and to the facility wide QA meetings at least quarterly to ensure ongoing compliance. Completion date July 23, 2018.	

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F 757	Continued From page 39 DON identified the missed FT4 lab test was concerning. The undated facility policy titled Nursing Home Lab Draw Workflow revealed the nursing home was responsible to track the lab draws from the initial order through to placement of the final results in the residents paper chart.	F 757		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment in order to promote independence with eating for 1 of 1 resident (R9) observed with difficulty while eating. Findings include: R9's modified admission Minimum Data Set (MDS) dated 3/1/18, indicated R9 had intact cognition, had diagnoses which included anemia, diabetes and cerebral palsy. The MDS indicated R9 ate independently, required extensive assist to dress and supervision for all other areas of daily living (ADL). R9's nutritional care area assessment (CAA) dated 3/2/18, identified an inability to perform ADLs without significant physical assistance;	F 810	Need for adaptive equipment when eating will be assessed, care planned, and communicated to staff to ensure residents receive the equipment needed to obtain their highest level of functioning. R9□s adaptive equipment for eating was reassessed by OT on 5-29-18, recommendations were made and care planned. However with each subsequent visit by OT to ensure plan was working, resident would change her mind of what she wanted or what was working for her. Plan was revised to ask resident her preference with eating utensils at each meal and provide them. All residents currently using adaptive equipment when eating have been re-evaluated by OT to ensure current plans are effective. New residents and	7/23/18

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F 810	Continued From page 40 however, did not identify need for specialized eating equipment and documented, "no difficulties." R9's care plan revised 4/19/18, revealed a goal to continue to feed self at meals and did not include the use of adaptive equipment. R9's care plan, revised 5/14/18 , listed R9 received a diabetic regular diet and regular fluid consistency, and directed staff to monitor weight and meal and fluid intakes. R9's care plan listed she had diagnosis of cerebral palsy, had uncoordinated movements history of stroke and gait and occupational therapy, physical therapy and speech therapy was ordered. Review of R9's progress notes revealed a note dated 4/9/18, by the registered dietitian (RD). The note identified R9 required some assistance to open packages and apply condiments. The note identified R9 utilized adaptive equipment at meals. The facility form titled Occupational Therapy Treatment Encounter Notes, dated 4/20/18, through 5/10/18, documented R9's hand weakness, shaking and trial of adaptive utensils. The therapy notes revealed the following: 4/20/18,- Problems with self-feeding and cutting up food. 4/24/18,- weighted silverware discouraged due to resident's weakness. 5/1/18,- R9 observed with slightly larger silverware and plan to trial built up handled silverware. 5/7/18, R9 observed with simulated cutting with medium sized built-up silverware and did well with them. 5/10/18,- R9 reported the silverware she had	F 810	residents identified as having a change in ability to eat will be referred to OT for evaluation, care planning, and monitoring for effectiveness. Needed adaptive equipment has been noted on individual resident menus to improve communication of resident needs to staff. Dietary staff education of these processes was completed 6-27-18. Nursing staff education regarding adaptive equipment when eating was completed 6-28-2018. The Dietary Department will now be posting updated lists of adaptive equipment in the dietary area which is only accessible to dietary staff. The Dietary Manager will monitor the changes to determine effectiveness. The Dietary Manager will conduct quality audits and present those results to the QA/PI committee monthly for three months and quarterly thereafter. Completion date July 23, 2018.	

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F 810	Continued From page 41	F 810		

been set up with was working well. Due to plateau R9 was discharged from therapy.

R9's dietary card dated 5/22/18, identified R9 required large, heavy silverware and an adaptive cup.

On 5/20/18, at 5:44 p.m. R9 sat at a dining table with four other women in the #3 dining room. R9 had regular handled silverware at her table setting and an adaptive cup with cover and dual handles. At 6:09 p.m. R9 received a hamburger and French fries, which she ate without the use of silverware. At 6:27 p.m. R9 independently removed the cover from a small container of pears with difficulty. R9 attempted to eat the pears with a spoon but was unable to do so. R9 with numerous attempts grasped a regular handled fork and attempted without success to cut the pears. R9 abandoned the attempts to cut the pears and speared the pear with the fork. With the pear on the fork R9 took bites out of the pear until it was small enough to place into her mouth. R9 did not attempt to use a knife to cut the pear.

On 5/22/18, at 7:54 a.m. R9 was seated in a wheelchair in the #3 dining room and her table setting had regular handled silverware. R9 independently eat the breakfast meal which included a hardboiled egg and a waffle with the use of the regular handled fork. R9 held the fork with the thumb and index finger of her right hand. R9 held the regular size handled knife with both hands to cut the waffle.

On 5/22/18, at 11:54 a.m. R9 was seated in the #3 dining room, the place setting in front of her had regular sized utensils.

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F 810	Continued From page 42 On 5/22/18, at 12:46 p.m. nursing assistant (NA)-F indicated R9 was able to make her needs known, had intact cognition and had no negative behaviors. NA-F indicated R9 was able to feed herself, utilized an adaptive cup at meals and a straw and did not utilize adaptive silverware. On 5/22/18, at 1:31 p.m. via a returned phone call, the RD indicated she believed R9 was currently utilizing the adaptive silverware. The RD identified the facility had the adaptive silverware but was not aware if the facility had provided the silverware to R9. The RD indicated she did not participate with resident care plans and identified the dietary manager (DM) as the person in charge of updating resident care plans. The RD indicated she had spoken to the DM regarding R9's need for the adaptive silverware. On 5/22/18, at 1:47 p.m. the DM verified she was responsible for updating the resident's dietary portion of the care plans. The DM indicated R9 did use adaptive silverware for meals. The DM described the silverware to have wider handles and a heavier weight than the regular dining room silverware. On 5/22/18, at 2:12 p.m. R9 indicated she hadn't been provided the adaptive silverware for three weeks. R9 indicated the knife was her main concern as she was able to manage with the regular fork and spoon, but is unable to hold and cut foods with the regular size knife. R9 described the silverware handles as a little larger but not the large black rubber handles. During a follow up interview on 5/23/18, at 9:59 a.m. R9 identified she was not provided with the	F 810		

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F 810	Continued From page 43 built up handled knife at the breakfast meal this morning. R9 again voiced her concern with not being provided the larger handled knife because she had a hard time holding on to the regular handled knife. On 5/23/18, at 1:18 p.m. the director of nursing (DON) indicated when adaptive equipment was recommended by the RD, speech therapy and / or occupational therapy it should have been added to the care plan and communicated so that all staff are aware in order to provide consistent care. The facility policy titled Assistive Device-ADL's effective date 4/16," All residents will be assessed on admission, quarterly and prn (as needed) for their abilities to perform ADL's at their highest level of functioning. A plan will be developed based on the resident's needs, as applicable. The plan will be reflected in the interdisciplinary care plan and be carried out by staff. "The policy included a category for eating to include: easy grip mug, adaptive silverware, special straws or mugs.	F 810		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		7/23/18

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F 812	Continued From page 44 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary equipment in the main kitchen of the facility to prevent the spread of foodborne organisms. In addition, the facility failed to ensure potentially hazardous foods were stored and thawed in a manner to prevent the growth of pathogenic microorganisms, and failed to ensure food items in the kitchen refrigerators were labeled and dated. Further, the facility failed to maintain the water and ice machines for 2 of 2 Stations, to prevent potential contamination for their residents who currently resided in the facilty. These deficient practices had the potential to affect all 49 residents residing in the facility Findings include: On 5/20/18, at 1:51 p.m. an initial tour of the main kitchen was completed with cook (CK)-A, the designated kitchen supervisor, who confirmed the following: -Hobart refrigerator small, undated, uncovered bowl with approximately 20 red grapes that appeared dry. CK-A stated "honestly, I don't know when they (grapes) are from" A clear plastic container, which	F 812	Dietary Area Concerns: The food found in unlabeled containers, containers with the lid off, the expired salsa sauce and items found on the floor have been disposed. The fan has been removed from the clean dish area. The top of convection oven and microwave have been cleaned. A cleaning procedure policy has been created so employees know the expectations of cleaning the dietary department. The cleaning schedule has been reviewed and updated. The Food Thawing policy was reviewed. Staff education was provided on June 27, 2018 with dietary staff regarding the new cleaning policy, food thawing policy, cleaning schedule, food labeling, proper storage of food, and survey results. The Dietary Manager or designee will monitor the cleaning schedule and completeness. The Dietary Manger will conduct audits to ensure cleaning is being completed and to evaluate the effectiveness of the changes. The Dietary Manager will present these audit findings at the QA/PI committee monthly for three months and then quarterly thereafter. Completion date July 23, 2018.	

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F 812	Continued From page 45 was undated, held eight hard boiled eggs, CK-A stated they were from that morning and she was going to make egg salad sandwiches that afternoon. -The top of a silver Vulcan convection oven had numerous black flaked substances and chunks of blackened materials. CK-A stated the oven racks had been removed from the oven and placed on top of the oven, leaving behind the black substance. -A Panasonic microwave was observed in the food production area that had a glass turntable inside. The turntable had an approximate 3 inch by 2 inch brown colored, baked on spill, a 2 inch by 1 inch white colored, baked on spill, and numerous light brown chunks of dried bread product, which CK-A identified as graham cracker crumbs. - A four-door standing refrigerator contained food items for residents and CK-A reported the bottom of the refrigerator was used for staff "snack bar". Inside the bottom left door of the refrigerator was a large, half full bottle of Rio Viego salsa with an open date, handwritten in green marker, of 4/17/18, with a printed sell by date of 4/19/18. CK-A stated the staff had not had a "snack bar" in a while. -The walk-in freezer had a container labeled minestrone soup 5/16/18, with a warped container and lid, which did not allow the lid to fit on to the container of the frozen soup, leaving the soup exposed. Next to the minestrone soup was another similar container dated 5/8/18, that was not labeled. CK-A confirmed the container had frozen broccoli cheese soup. The soup froze in a	F 812	Ice Machines: The two ice machines cited were cleaned May 22, 2018. Staff education was provided on May 29, June 13 and 26, 2018 to Environmental Services frontline staff regarding changes. The Ice Making machine policy has been reviewed and updated to include the daily check of the ice machines. In addition, Environmental Services will now have a daily ice maker cleaning schedule checklist. De-scaling frequency has been changed to quarterly. Environmental Services Director and Lead Housekeeper will monitor the conditions of ice makers on a regular basis. Environmental Services Director or designee will conduct quality assurance audits to ensure effectiveness of these changes. The results of the audits will be brought to the QA/PI committee on a quarterly basis. Completion date July 23, 2018.	

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manner that pushed the lid up, making it not possible to close. The top of the soup was covered in a white frost-like appearance that extended into the inside portion of the lid.

-The dry storage room had a 25 pound bag of Crystal sugar leaning against a large sack of dry oats. The oat sack was leaned against the middle storage rack, both the sugar and oat sacks rested directly on the floor. CK-A stated the sugar and oats were to be stored on the bottom shelf of the storage rack, but the rack was full, so they were stored directly on the floor.

-At the end of the kitchen tour a metal wheeled cart was observed next to the Vulcan convection oven. On top of the metal cart was an opaque plastic six inch pan which held two chubs of frozen ground hamburger in clear plastic wrapping. The water surrounding the frozen beef radiated heat, and steam rose from the water in the pan. CK-A stated the frozen beef was to be used for sloppy joes for that days supper meal. CK-A stated they "did not start thawing it 2 days ago, like they should have and we are thawing it quick".

On 5/23/18 at 9:55 a.m. during a follow up tour of the main kitchen dietary aide (DA)-A confirmed a white Lasko fan mounted on the wall blew air over the clean dish room of the kitchen. The fan blades were covered in a thin black substance. The fan blades were covered by a plastic guard, with the back guard covered in the same black substance and the front guard with black substance and attached black fibers blowing towards the clean dishes.

On 5/23/18, at 1:54 p.m. dietary manager (DM)-A

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stated the usual process for thawing frozen meat was to take the meat out of the freezer 2-3 days ahead of time and place it in the walk-in cooler. DM-A stated the frozen beef from 5/20/18, was forgotten and a "fluke". DM-A stated the frozen hamburger should have been under running luke warm water in the sink to thaw and not in a tub of hot water on a cart. DM-A stated leftovers should be placed into containers that are dated and labeled. If the leftover was to be used in the next three days, then it would be placed in the refrigerators, if not then should be placed in the freezer. DM-A stated the broccoli cheese soup from the freezer was placed in the freezer when the soup was still hot and it expanded when freezing, which made the lid come off. DM-A was not aware if the soup temperature was checked to ensure proper cooling times when going from hot to frozen state. She stated the minestrone and broccoli soups were thrown away. DM-A stated the sugar and oats bags would have been delivered on 5/17/18, and should not have been stored directly on the floor. DM-A observed the four-door refrigerator and opened the bottom left door where a bottle of El Paso salsa was opened and undated with a third of the product missing, Rio Viego salsa with open date of 4/17/18, and a flat of pre-made muffins dated 4/21/18. DM-A was unaware how long the salsa could be stored opened in the refrigerator, and stated the residents don't typically use salsa, but they could have a potential to use items from that refrigerator. She stated the muffins were bought pre-made and kept frozen. When the container was first thawed, the staff dated it 4/21/18. The muffins were then again frozen and then taken out on 5/18/18, for use on Monday 5/21/18, but not dated. DM-A then observed the white Lasko fan that continued to blow air onto the clean

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dishes. She confirmed the black substance built up on fan blades and plastic guard was a concern, as she unplugged the fan from the wall. DM-A stated the fans were to be cleaned weekly. DM-A confirmed the black substance from on top of the Vulcan convection oven was burnt food material from inside the oven and when the racks were set on top of the oven, the black substance transferred to the top of the oven. DM-A stated the ovens were cleaned weekly, but had been out of oven cleaner for "a while". DM-A also stated the microwave oven should be cleaned after use if soiled, but should be cleaned at least daily.

Review of the Daily Chores Checklist, dated May 2018, which listed various cleaning duties of the dietary staff, each done weekly with areas to initial when completed. The checklist listed "wash all fans with Shift 3" and indicated this had not been completed at all in May. The checklist also listed "Wash all fans with Shift 2" and indicated this was last completed 5/4/18. The checklist also listed "Coat racks with oven cleaner and put in garbage bag to sit over night" and "Finish cleaning convection oven" both indicated this had not been completed at all in May.

A facility policy titled Thawing of Foods, last revised 5/2017, indicated to provide safe consumption of food for residents, thaw frozen food in the refrigerator at a temperature at or below 41 degrees, or thaw frozen food completely submerged under clean, drinkable running water. The water should be under 70 degrees or below and water should be at sufficient velocity as to agitate and float off loose particles in an overflow. If thawing in running water, check the temperature of the food every 30 minutes.

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A facility policy titled Food Storage Perishable and Dry Storage, last revised 6/30/17, indicated perishable food would be stored in a manner to safeguard the health of the residents. All foods must be in covered containers or otherwise protected. Dry storage, all products need to be on shelving and not left on the floor.

A facility policy titled Cleaning Procedures, last reviewed 11/2017, indicated the dietary department would be maintained in a sanitary condition. The DM would be responsible for cleaning procedures used in conjunction with posted cleaning schedule. Employees will be trained to these procedures during orientation and all employees would be responsible to follow procedures as written.

ICE MACHINES

On 5/22/18, at 2:24 p.m. a tour of the Station I and II ice and water machines was conducted with the environmental services director (ESD)-A to identify concerns:

-Station I kitchenette, the water and ice machine was observed to have a white, crusted, hard water lime scale build up under the plate where the ice dispenser came out of the machine. Around each side of the dispenser were two faint, white, approximately quarter of an inch wide lime scale stains that ran down from the dispenser to the runoff collection tray. On the counter where the ice machine sat was an outline of white, crusted, hard water lime scale build up surrounding the entire machine.

-Station II kitchenette, the water and ice machine was observed to have a white, crusted, hard

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MADISON HEALTHCARE SERVICES	900 SECOND AVENUE MADISON, MN 56256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 50	F 812		

water lime scale build up under the plate where the ice dispenser came out of the machine. Each bolt that secured the dispenser had areas where approximate quarter inch, but not longer than half inch, lime scale stalactites hung. Around each side of the ice dispenser were two faint, white, approximately quarter of an inch wide, lime scale stains that ran down from the dispenser to the runoff collection tray. The stainless steel wrap near the water tray was bubbling out and started to peel. The water collection tray had an area directly below the ice dispenser that had lime scale and a brown substance build up. The grates on the collection tray also had areas where the protective coating had worn away and the metal had rusted.

ESD-A stated Station I ice and water machine needed de-scaling. ESD-A stated Station II ice and water machine also needed de-scaling, as he rubbed at the lime scale, tiny visible flakes of lime scale fell from the machine into the collection tray and he added, a piece of lime scale could fall into a glass.

On 5/23/18, at 9:45 a.m. ESD-A stated maintenance staff cleaned the water and ice machines yesterday, and the machines are set up on preventative maintenance cards for every January and July. ESD-A stated the last time the machines were de-scaled was 1/25/18, and looking at the amount of lime build up the de-scaling scheduled should be stepped up.

On 5/23/18, at 12:36 p.m. clinical manager (CM)-B stated all residents on Station I have water or ice from the Station I kitchenette machine. She stated two of the residents have modified fluids, but the water would still be

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F 812	Continued From page 51	F 812		

received from the machine and then thickened.

On 5/23/18, at 1:07 p.m. CM-C stated all residents on Station II would have water and/or ice from the Station II kitchenette machine.

Review of Preventative Maintenance (PM) card for the Manitowoc Nugget Ice Machine Station I dated 9/17/15, indicated a visual inspection was required every 6 months, cleaning (which consisted of de-lime unit and clean condenser) was required every 6 months was last completed 1/25/18.

Review of Preventative Maintenance (PM) card for the Manitowoc Nugget Ice Machine Station II dated 8/2013, indicated a visual inspection was required every 6 months, cleaning (which consisted of de-lime unit and clean condenser) was required every 6 months was last completed 1/25/18.

Review of Manitowoc RNS12 Model Nugget Ice Machines, Installation Use & Care Manual dated 10/13, indicated to clean and sanitize the ice machine every six months for efficient operation. "If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment". Under Section 4 Maintenance Procedures it listed Clean/Sanitizing Procedure: "This procedure must be performed a minimum of once every six months".

A facility policy titled Ice Making Machines, last reviewed 2/2018, indicated all ice shall be made and dispensed in a sanitary manor in order to minimize opportunity for contamination. On a

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F 812	Continued From page 52 regular schedule biannually: thoroughly clean machine and the parts which included, de-lime.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		7/23/18

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F 880	Continued From page 53 (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 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean resident clothing and facility linens were handled in a manner that prevented contamination during the sorting and folding of clean linens. This practice had the potential to affect all 49 residents served by the facility laundry.	F 880	The black Air King fan from the folding /sorting room has been removed. The daily/weekly and monthly cleaning schedule has been updated and now includes listing of all fans in the Environmental Services laundry department. All fans in the laundry area	

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F 880	Continued From page 54 Findings include: On 5/23/18, at 9:23 a.m. during a facility laundry tour, a separate drying and folding room was observed. Environmental services director (ESD) stated the facility had a separate clean room for drying, sorting and folding clean items. Resident clothing and facility linens were dried and then moved to large folding/sorting tables in the middle of the room. Facility linen and resident clothes were then sorted and folded on the tables and placed on covered carts to be transported upstairs to the resident rooms and clean linen storage. A large, black, Air King fan was positioned near the far wall of the room and pointed directly over the folding tables. The fan blades were covered with a black/gray substance that started at the tip of the blade and continued down the blade towards where the blade connected in the center. The fan blades were encased with black metal fins, on the fins in front of the fan blades were covered with up to one inch gray/black fibers that were pointing towards the folding tables due to the pressure of air from the fan. ESD confirmed the black/gray substance and fibers on the fan and brushed the front fan fins with his hand, releasing fibers from the fins and the air current blew the fibers over the folding table. On 5/23/18, at 12:55 p.m. housekeeping (HK)-A stated she was assigned to the laundry department about two days per week. HK-A stated all residents at the facility would use the facility's laundry service due to using linens or towels, if not their own personal laundry. HK-A confirmed resident laundry and linens were folded on the tables in the dryer room and stated she	F 880	will be cleaned weekly. Staff education was provided on June 26, 2018 regarding these changes. It will be the responsibility of the Environmental Services Director or Lead Housekeeper to monitor the changes. The Environmental Services Director or designee will conduct quality audits to ensure compliance and effectiveness of changes. The Environmental Services Director or designee will bring those audits to the QA/PI committee on a quarterly basis. Completion date July 23, 2018.	

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F 880	Continued From page 55 could not recall the last time she had cleaned the black Air King fan in the dryer room, but there was a cleaning schedule that included cleaning the fan. Review of facility form titled Laundry Cleaning Schedule--Extra Jobs For When Extra Time, dated 12/31/17, indicated the folding room fan was lasted cleaned 4/9/18. The form also indicated the sorting room fan had not yet been cleaned for the quarter of April to June, 2018. A policy for cleaning in the laundry room was requested, and none was provided.	F 880		

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

FB382026

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/22/2018**

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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 May 22, 2018. 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 49 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
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