Electronically delivered
August 12, 2021

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

RE: CCN: 245382
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 22, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	C 07/22/2021

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

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F 000	INITIAL COMMENTS On 7/21/21 through 7/22/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5382032C (MN74714), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately monitor,	F 689	• Education was provided for the nursing staff on the facility elopement	9/3/21

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

Electronically Signed | 08/20/2021

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F 689	Continued From page 1 provide appropriate supervision when out-of-doors and follow facility policies and procedures for supervision for 1 of 1 resident (R1) who eloped from the facility without staff knowledge. Findings include Review of the 7/12/21 5:07 p.m., report to the State Agency (SA) identified R1 eloped from the facility through the clinic entrance. R1 was told to stop by the attached building clinic staff, but continued exit. R1 was found later by facility staff across town at the liquor store. Review of the 7/16/21, facility 5-day investigation report submitted to the SA identified R1 exited the facility on 7/12/21 at 4:12 p.m., the clinic receptionist called the nursing home charge nurse at Station 2 and reported R1 exited the clinic and was heading right at the end of the facility building. The nurse care coordinator and charge nurse immediately exited the facility to search for R1. Another nurse searched for R1 by vehicle. At 4:23 p.m., R1 was found trying to enter the side door of the liquor store. The care coordinator redirected and supervised R1 back to the facility. The doors connecting the nursing home to the clinic were closed when the resident eloped. R1 was educated to notify staff when leaving the building so she could be supervised by staff. R1 was reminded she had signed an agreement to do so. R1 verbalized understanding. A meeting with the Ombudsman was arranged to discuss R1's rights and to confer any interventions on 7/15/21. R1's physician agreed to meet with R2 every 2 weeks when able, and R1 was offered cemetery visits on a monthly basis to visit her husband's graveside. A wander	F 689	policy on 7/29/21. • Education provided to all nursing staff to include electronic health record training on risk management documentation, incident follow up, the use of the 24-hour report and clinical alerts within the electronic health record. Will be completed on all staff by Sept. 3, 2021. • All nursing staff will be refreshed on the use of the Kardex feature in the electronic health record and the responsibility for checking the Kardex for any changes in the plan of care. This training will have emphasis on following the care plan and avoiding interpretation of goals and interventions. Will be completed on all staff by Sept. 3, 2021. • Safety agreement has been updated to reflect the need for the resident to have supervision when leaving the facility. Resident agrees to notify the Care Coordinator in advance of outings to facilitate obtaining a volunteer to go with her, particularly on weekends. • Resident education has been completed regarding the facility sign out book and the need for that book to be used when leaving the facility with friends or volunteers. • Residents have completed the relocation to the new building and the resident verbalizes contentment with her new space. Along with the new location, the prior exit path this resident used will be unavailable to her. • Maintenance will perform safety inspections on resident's personal scoter at a minimum of quarterly. • Resident's care plan has been	

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F 689	Continued From page 2 guard was offered. R1's scooter company was contacted to adjust R1's scooter to a slower speed for safety. Counseling for alcohol addiction was offered to R1, but services were declined. R1 was under the care of a psychiatrist. R1 eloped from the facility on 4/2/21, 5/16/21, and 5/28/21. R1 had an attempted elopement on 4/10/21, but was found in the facility. R1's care plan was followed. No injury occurred. R1's care plan was modified to prevent reoccurrence. Polices and procedures were followed at the time of the incident. No changes to the policy were required. R1's 4/30/21, quarterly Minimum Data Set (MDS) identified R1's cognition was intact. R1 had no behaviors or wandering. R1 required extensive assistance of 2 staff for bed mobility, transfers. R1 was independent with locomotion on and off the unit and required no assistance from staff. R1 used a motorized wheelchair for locomotion. R1's diagnoses included anxiety, cerebral palsy, depression, alcohol dependency, and weakness. R1's 7/21/21, care plan identified R1's cognition was intact. R1 was unaware of her safety needs and had a history of elopements. R1 also had a history of alcohol abuse and addiction and used ineffective coping skills. R1 used a motorized scooter for mobility. R1 had a history of transferring without staff assistance. R1 was provided education about the risks of not having assistance with transfers and leaving the facility without assistance. R1 verbalized and signed an understanding of risks of her actions. R1 required assistance of two staff to transfer her from surface to surface with a mechanical lift. A call light was to be within R1's reach at all times, and staff were to encourage her to use it to call for assistance. Staff were to allow R1 freedom to be	F 689	updated to reflect staff options to assist with going for walks. This will facilitate nursing staff to contact appropriate ancillary staff to assist. Special instructions have been added for CNAs to alert them to the fact that this resident is at risk for elopement. They are required to sign off understanding every shift. • Because the resident has refused alterations to her personal scoter for safety reasons, the resident will be screened by therapy quarterly and as needed for any changes in functional ability. • Care Coordinator will review counseling options for this resident monthly during scheduled visits. • Faith Lutheran Church will be contacted for Chaplain visits within the facility as their schedule allows, for additional support. • Telehealth Psychiatric options will be explored as the resident allows, as she has refused counselors in the past with a preference for “professional” psychiatrist. • All residents at risk for elopement/wandering will have a care plan review completed by 8/31/21 • Audits to ensure care plan compliance and to track any incidents will be completed weekly x 4 weeks, then monthly x 3 months, then quarterly with each care plan review.	

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F 689	Continued From page 3	F 689		

outdoors in the private, enclosed area at the facility. R1's physician offered to see R1 every 2 weeks for 30 minutes when able. Staff were to explain safety issues and offer a wander guard routinely. R1's scooter company was contacted to find a way to regulate the speed on her scooter. Staff were to offer R1 activities she enjoyed and monthly cemetery visits. Staff were to also offer to go on outdoor outings with R1 daily. Additionally, R1 was offered alcoholics anonymous meetings and mental health counseling services, which had previously R1 declined.

R1's 4/20/21, Safety Agreement identified R1 agreed not to leave the care center without properly notifying a member of the clinical staff where she was going and what time R1 expected to return. It was noted a breech of the contract could cause R1 to be in an unsafe environment, increasing R1's risk for harm. The contract made no mention of the facility's policy and procedure to leave the building and was not updated to include staff were to accompany R1 out of the facility.

Interview on 7/21/20 at 12:45 p.m. with nursing assistant (NA)-A identified R1 had eloped a few times. R1 refused to wear a wander guard. R1 was supposed to ask staff to assist her when she wanted to go outside.

Interview on 7/21/21 at 12:46 p.m., licensed practical nurse (LPN)-A identified all doors had alarms, but R1 refused to wear a wander guard. R1 was alert and her cognition was intact. R1 typically left through the therapy entrance door when she eloped. Staff were required to have visual contact with R1 every 30-minutes to monitor for elopement. R1's room and the exit

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F 689	Continued From page 4	F 689		

were not visible from the nurse station. The door to courtyard was always locked. R1 had to ask to go to the courtyard but she rarely asked to go into the courtyard. The charge nurse was responsible for documenting offering daily outdoor activity. LPN-A stated staff had not offered R1 outdoor activities daily because R1 was supposed to ask staff to go out with her.

Interview on 7/21/21 at 12:47 p.m., with nursing assistant (NA)-A identified the day before R1 eloped, she wanted to go to an outdoor church service. There were not enough staff, and she was very upset. NA-A was unsure if the case manager was aware she wanted to go. On the morning of 7/12/21, R1 had no signs of being upset prior to her elopement. R1 usually eloped through the therapy doors near her room. R1 refused to wear a wander guard. R1 was on 30-minute checks to ensure she was in the building, but R1's cognition was intact, and she knew when to leave, usually when it was busy. R1 occasionally used the courtyard. R1 had not asked to go out lately, NA-A felt, because of the heat. Staff had not proactively offered to take her out daily because R1 was to ask staff to take her outside. Sometimes, there were not enough staff to assist R1 outdoors when she wanted to go outside. When R1 "snuck out" of the facility, NA-A stated it was usually in the mid-afternoon between 2:00 and 4:00 p.m., to get liquor.

Observation on 7/21/21 at 2:00 p.m., of R1's room, the therapy entrance, and the Station 1 nurse identified R1's room and the nurse station were located at opposite ends of the hallway. R1's room was located near the corridor known as the Link. The Link connected the nursing home to the clinic and hospital. A set of unlocked

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F 689	Continued From page 5	F 689		

double doors separated the link from the nursing home. The therapy department entrance was in the link near the nursing home entrance. The door to the therapy department was open from the inside but locked from the outside. A set of unlocked double doors was located at the entrance of the Link. connecting the nursing home to the therapy entrance. The therapy department had an outdoor entrance and an entrance connected to the link. The link door locked from the outside but was unlocked inside the Link. Both entrances were not within sight of any nursing station and was not visible from the therapy department reception desk.

Observation on 7/21/21 at 3:10 p.m., of R1 identified R1 was in the hallway near her room. R1 approached her room, and opened door using her scooter. R1 drove scooter inside her room. R1's door has marks on the doorway where the basket and scooter base rubbed on the door. A sign on the door identified to keep the room door closed according to R1's preferences. R1 sitting upright in her scooter.

Interview on 7/21/21 at 3:08 p.m., with R1 identified she had received a new scooter about 2 weeks ago. R1 liked to leave the facility when the weather was nice. R1 was supposed to notify staff when she was leaving the facility. R1 identified she only got to go outside when someone was there to help her. R1 was not offered to go outside daily by staff. There were not always enough staff to go with her when she wanted to go out, and often they were too busy to go with her. R1 recalled recently, she wanted to go to an outdoor church service on 7/11/21, the day before she eloped. She had told staff she wanted to go a few days before the service. She

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F 689	Continued From page 6	F 689		

was unable to recall who she told. On Sunday, staff member called in sick, so there was not enough staff to take her. R1 was very upset, because she had told staff she wanted to go and was told there were enough people to help her get there. On that Sunday, she was informed she also had to notify the director of nursing (DON) when she wanted to go to an event so they could make arrangements for her to go. R1 was unaware she had to notify the DON prior to the day of the service. R1 was able to use the courtyard when she asked staff to let her outside. R1 identified she had not used the courtyard because there was very little room, staff were too busy, and there was nothing going on out there. R1 identified she liked to garden when she lived at home. There was not much gardening done at the facility because they were building a new building, and the current courtyard she could go to was going to be removed, so there was nothing out there. R1 identified when she went out of the facility, she used the door the therapy entrance near her room. When out in the community, R1 identified she preferred to use the road because the sidewalks were uneven and made traveling uncomfortable. R1 also identified she liked to drive her scooter fast when out, and the facility was looking into a way to slow it down. R1 was working with therapy to become stronger because she leaned to her right side when tired. R1 tried a bolster, but it was not useful.

Interview on 7/21/21 at 2:30 p.m., with the Ombudsman identified she had met with the facility on 7/15/21, to discuss R1's situation. The ombudsman identified R1's issues were complex. She identified the facility was mostly interested in keeping R1 within the facility at the time of her visit and had asked her to look into keeping doors

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F 689	Continued From page 7	F 689		

locked in the facility to maintain R1's safety. The Ombudsman was looking into the facility's request. She suggested the facility focus on resident safety rather than keeping her restricted to the facility. She forwarded an email sent to the facility with suggestions made during her visit on 7/15/21. The ombudsman had not received any further communication from them following her visit. Her concern was that the facility was more focused on keeping her from leaving the facility, rather than on keeping her safe when out in the community. At the present time, she was able to make her own decisions, and the facility was responsible for ensuring safety as much as possible. R1 presented a difficult situation for the facility, and the ombudsman suggested to have follow-up visits with the facility to meet R1's needs.

Review of the 7/16/21, email identified the following:
1) R1 had the right to leave the facility and can't be held captive The ombudsman encouraged the facility to develop a care plan to support R1's desire to go out of the facility and scoot around with supervision from a staff person, a volunteer, or other persons to enhance her safety. The ombudsman suggested to rotate persons accompanying R1 when on her outings between direct care staff, volunteer, leadership staff or other qualified persons.
2) To assure that R1 had a way to call for help such as a pendant, and to have some type of identifying or reflective device or traffic visibility such as a tall flag on the back of the scooter, a reflective vest or both. She also suggested to explore adding reflective tape, horns, or other tools to increase her visibility.
3) To provide frequent maintenance checks of

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F 689	Continued From page 8 R1's scooter to ensure it was in good repair, including tires, brakes, throttle, and the battery. 4) To explore whether R1 wanted to go to the liquor store or to have other regular outings that were just as fulfilling. 5) To discuss with R1 whether or not she would be happy going to another store to buy non-alcoholic beverages. 6) To explore what the driving force is behind R1's desire to leave the facility, and identify whether she wanted liquor, socialization; wanting to be outside, or whether R1 enjoyed getting away without being seen. 7) To present a plan to R1, to provide her with an opportunity to be amenable to asking someone to walk with her, and to continue to provide R1 reminders to ask for assistance to go outside. 8) As a last resort, when R1 desired to out alone, someone could discreetly keep an eye on her from a distance, though this was not the best approach considering the route from her room, out the door, and down the hill. 9) R1's physician could increase visits to alleviate R1's anxiety. Interview on 7/22/21 at 11:41 a.m., with the clinic receptionist identified she saw R1 drive her scooter down the hall, glance at her and leave through the clinic door on 7/12/21. The receptionist was on the phone at the time and was unable to intervene. The receptionist immediately called the clinic and notified the charge nurse. Once outside, R1 quickly drove her scooter down the sidewalk into the parking lot and turn right out of sight on to the adjacent street. After the elopement, a radiologist commented to the receptionist R1 was in the corridor connecting nursing home to the clinic but had not realized R1 was eloping.	F 689		

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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 689	Continued From page 9 Interview on 7/22/21 at 11:52 a.m., with the occupational therapist (OT) identified R1 had received a new scooter and was working with OT for safe use at the time of the elopement. She was unaware R1 had eloped on 7/12/21. R1 was supposed to always have supervision by all staff when outside the facility because she was impulsive and unable to maneuver her motorized scooter safely outside the facility on her own. R1 only wanted to use the road, and not the sidewalks per recommendations. R1 also was not safe regulating her speed on the scooter outdoors. She had not recommended any safety equipment for R1's scooter such as a flag or because she was not yet safe to operate her scooter independently outdoors. R1 was not evaluated for traveling off campus because she had not yet operated her scooter safely on campus. OT had instructed R1 to only exit the facility through the main entrance. Staff were educated to enforce safe use of her motorized scooter. The OT had educated R1 to no longer leave the facility through the therapy entrance, and encouraged her to leave the building through the main nursing home entrance, but had not communicated that to nursing home staff. Interview on 7/22/21 at 11:15 p.m., with registered nurse (RN)-A identified she was on duty when R1 eloped on 7/12/21. The clinic receptionist notified the Station 2 charge nurse staff R1 left through the clinic entrance. R1 was not located near the facility on foot, so RN-A and another nurse searched for R1 in car. R1 was found at the liquor store trying to enter through the side door. RN-A redirected R1 back to the facility. RN-A followed R1 on foot. R1 was unable to obtain her liquor order and was upset and angry with RN-A. R1	F 689		

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F 689	Continued From page 10	F 689		

attempted to outrun NA-A on her scooter. R1 drove at a high speed and was unsteady while seated on her scooter, causing R1 to lean off the side of the scooter. At one point, R1 almost hit her head on a dumpster. At intersections, R1 ignored the curb ramps and almost drove straight off the curbs into the intersections. RN-A cued R1 to slow down and remain on the sidewalks and stop at intersections. No injuries occurred. When R1 was interviewed, she identified she had called the liquor store to get vodka and planned to pick it up. R1 had not notified staff of her plan. RN-A was not sure of the initial route she took to the store, but typically, R1 route zig-zagged route through the streets. To get to the liquor store, R1 had to cross at least two busy streets, Main Street, and Highway 40. The Case manager had never accompanied R1 on an outing, so she was unsure how R1 navigated when she was not upset. R1 was currently working with OT for safe operation of her scooter. RN-A had not audited wether staff were offering R1 outings on a daily basis because R1 was able to ask staff to accompany her outside. RN-a confirmed there was a call-in on 7/11/21. RN-A was not aware R1 planned to attend an outdoor church service until 7/12/21. She expected R1 and staff to notify if there were any plans R1 had for off-site activities in order plan to ensure someone was available to assist her. Staff notified of any changes in resident care, including elopement in a communication book located at the nurse desks. Staff were expected to read the communication book, care plan, and receive nurse reports for updates for resident care. A new process was piloted in the past month to have updates posed in the electronic medical record (EMR) communication section for staff to review at the start of their shifts. RN-A verified R1's elopement

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F 689	Continued From page 11	F 689		

was not included in the communication information book and the EMR. She expected R1's elopement to be included in both forms of communication.

Observation on 7/22/21 at 11:35 a.m. of the R1's room, the Link entrance, therapy entrance and the R1's 7/12/21, exit route with RN-A identified the Link was not visible from the any nurse stations and the therapy department. The doors to the link were not locked. The therapy door to the link only locked from the outside. The Link led to an elevator. R1 had to enter the elevator to reach the clinic entrance. The elevator opened into the wing containing the radiology department. The clinic reception desk was at the end of the wing facing the clinic entrance. The clinic entrance was connected to a large parking lot, connecting to the adjacent city street. The exterior wall of the hospital and clinic extend down the right side of the parking lot, blocking the right side view of the street.

Interview on 7/22/21 at 12:08 p.m., with NA-C identified she has been on a year leave of absence. It was her first day returning to work. She was not notified or R1's recent elopements and was not notified of R1's new interventions. Staff were expected to read the communication book, and receive report from the charge nurse for changes in resident care. She had not read R1's Kardex or the communication book prior to the start of her shift. She was not notified R1 had eloped during nurse report.

Review of the July 2021, communications section of the electronic record identified the first communication note was dated 7/9/21. The communization note made no mention R1 eloped

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F 689	Continued From page 12 on 7/12/21. Review of the July 2021, Resident Concerns sheets used for daily nurse report identified the following: On 7/12/21, R1 had a new order for a dressing change and a follow-up appointment on 7/14/21. The sheets made no mention R1 eloped on 7/12/21. Interview on 7/22/21 at 3:30 p.m., with the interim DON identified she assumed the interim position about two weeks ago. All staff were educated on elopement annually. She expected all staff to be notified of R1's elopement and any interventions by reading the communication book and EMR. Charge nurses were also expected to notify staff of R1's status and interventions during shift change. R1 was educated regarding new expectations of having staff supervise her on outings. The DON verified R1's most recent safety agreement occurred on 4/20/21, A revised safety agreement was not implemented after R1 required supervision and the agreement had not included the policies and procedures on how to notify staff of leaving the facility. Interview on 7/22/21 at 4:00 p.m., with the administrator identified R1's situation was "complex". R1 was able to make her own decisions, however she was not making safe decisions when she chose to leave the facility. R1 was cleared to operate her scooter outdoors without supervision. Staff were to know what to do to ensure R1 was safe. R1 had i history of noncompliance. The administrator agreed the facility was responsible to ensure R1's safety while in and out of the building, and had contacted the ombudsman to ensure R1's rights were addressed while also keeping R1 as safe as	F 689		

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F 689	Continued From page 13 possible. R1's interventions were to be evaluated for effectiveness and new interventions implemented when needed after each elopement. Review of the April 2021, Elopement/Missing Resident policy identified staff and family will sign out a residents in the specified book when arrangements were made to leave the facility. Social services was to provide education annually to residents at a resident council meeting and periodically as needed. Staff were to identify residents at risk for elopement. The resident's plan of care was to be specific and include interventions to minimize the risk of elopement. When an elopement occurred, licensed staff were to document details of the event. The event was reviewed by the quality team at the next meeting with revisions made to the policy and plan of care as necessary. Staff were to be educated regarding the elopement policy during general orientation and annually thereafter.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 12, 2021

Administrator
Madison Healthcare Services
900 Second Avenue
Madison, MN 56256

Re: Event ID: HDIG11

Dear Administrator:

The above facility survey was completed on July 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/21/21 through 7/22/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5382032C (MN74714) however NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		